

USFHP Prior Authorization Request Form for
zanubrutinib (**Brukinsa**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? Call 1-877-880-7007

<https://www.usfamilyhealth.org/for-providers/pharmacy-information/>

Prior authorization does not expire. Clinical Documentation may be required.

Step 1 Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID # _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

Step 2 Please complete the clinical assessment:

1. Is the requested medication prescribed by a hematologist or oncologist?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 2
2. Is the requested medication prescribed in consultation with a hematologist or oncologist?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Is the patient 18 years of age or older?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
4. What is the diagnosis or indication?	<input type="checkbox"/> Pathologically confirmed relapsed or refractory mantle cell lymphoma (MCL) – Sign and date below <input type="checkbox"/> Waldenstrom's macroglobulinemia (WM) – Sign and date below <input type="checkbox"/> Relapsed or refractory marginal zone lymphoma (MZL) and has received at least 1 anti-CD20-based regimen- Sign and date below <input type="checkbox"/> Chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) – Sign and date below <input type="checkbox"/> Other – Proceed to question 5	
5. The diagnosis IS NOT listed above but IS cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation. To facilitate approval, please list the diagnosis, guideline version, and page number:	<p align="center">_____</p> <p align="center">Sign and date below</p>	

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

_____ Prescriber Signature

_____ Date