US Family Health Plan
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**

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 patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication prescribed by or in consultation with a hematologist/oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. For which indication is the requested medication being prescribed?	☐ **Pathologically confirmed relapsed or refractory mantle cell lymphoma (MCL)** – Proceed to question **6** ☐ **Waldenstrom's macroglobulinemia (WM), a rare non-Hodgkin lymphoma** – Proceed to question **6** ☐ **Relapsed or refractory marginal zone lymphoma (MZL) who have received at least 1 anti-CD20-based regimen** – Proceed to question **6** ☐ **Other** – Proceed to question **4**	
4. Please provide the indication or diagnosis.	_____ Proceed to question **5**	
5. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**

6. Will the patient be monitored for bleeding, infection (including opportunistic infection), cardiac arrhythmias, secondary primary malignancies, and cytopenias?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Will the patient use sun protection in sun-exposed areas?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. What is the age/gender of the patient?	☐ **Male - Sign and date below** ☐ **Female of childbearing age** – Proceed to question **9** ☐ **Female not of childbearing age - Sign and date below**	
9. Does the patient agree to use effective contraception during treatment and for at least 1 week after the cessation of treatment?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Has it been confirmed that the patient is not pregnant by (-) negative HCG?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Has it been confirmed that the patient will avoid breastfeeding during treatment and for at least 2 weeks after the cessation of treatment?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

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

_____ _____
Prescriber Signature Date