US Family Health Plan
Prior Authorization Request Form for
Eflornithine tablets (Iwilfin)

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**

Prior authorization does not expire.

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:**

Question		
1. Is the requested medication being prescribed by or in consultation with an oncologist?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Does the patient have high-risk neuroblastoma?	☐ Yes Proceed to question **5**	☐ No Proceed to question **3**
3. What is the diagnosis or indication?	______________ Proceed to question **4**	
4. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is the requested medication being used to reduce the risk of relapse?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Has the patient had at least a partial response to prior multiagent, multimodality therapy including anti-GD2 immunotherapy?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

7. Is the provider aware of all warnings, screening, and monitoring precautions for the requested medication?	☐ 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 ____________

[14 August 2024]