US Family Health Plan

Prior Authorization Request Form for

Pirtobrutinib (Jaypirca)

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 being prescribed by or in consultation with a hematologist or oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Does the patient have pathologically confirmed relapsed or refractory mantle cell lymphoma (MCL)?	☐ Yes Proceed to question **6**	☐ No Proceed to question **4**
4. What is the diagnosis or indication?	_____ 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 patient's gender?	☐ Female Proceed to question **9**	☐ Male **Sign and date below**
9. Is the patient of childbearing potential?	☐ Yes Proceed to question **10**	☐ No **Sign and date below**
10. Does the patient agree to use effective contraception before starting treatment, during treatment and for at least 1 week after cessation of therapy?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **12**
12. Has it been confirmed that the patient is not pregnant by negative hCG (human chorionic gonadotropin)?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Will the patient avoid breastfeeding during treatment and for at least 1 week 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 _____