US Family Health Plan

Prior Authorization Request Form for

Methotrexate (Jylamvo, Xatmep) oral solution

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**

PA criteria does not apply to children 12 years of age and younger.

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. What is the requested medication?	☐ Jylamvo - Proceed to question **2** ☐ Xatmep - Proceed to question **3**	
2. Does the patient have acute lymphoblastic leukemia (ALL), mycosis fungoides, relapsed or refractory non-Hodgkin lymphoma, rheumatoid arthritis, severe psoriasis, or active polyarticular juvenile idiopathic arthritis?	☐ Yes Proceed to question **4**	☐ No Proceed to question **5**
3. Does the patient have a diagnosis of acute lymphoblastic leukemia (ALL) or active polyarticular juvenile idiopathic arthritis (pJIA)?	☐ Yes Proceed to question **4**	☐ No Proceed to question **5**
4. Does the patient have a history of difficulty swallowing tablets or has a medical condition that is characterized by difficulty swallowing or inability to swallow?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
5. Please provide the diagnosis.	_____ Proceed to question **6**	
6. Does the patient have a history of difficulty swallowing tablets or has a medical condition that is characterized by difficulty swallowing or inability to swallow?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

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

3

Prescriber Signature Date