US Family Health Plan
Prior Authorization Request Form for
Lazertinib (Lazcluze)

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**

Clinical documentation may be required for approval.
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:**

1. Is the requested medication prescribed by or in consultation with a hematologist or oncologist?	☐ Yes Proceed to question **2**	☐ No **Stop** **Coverage not approved**
2. Is the patient greater 18 years of age or older?	☐ Yes Proceed to question **3**	☐ No **Stop** **Coverage not approved**
3. Will the patient be given prophylaxis for the prevention of venous thromboembolism during the first four months of treatment?	☐ Yes Proceed to question **4**	☐ No **Stop** **Coverage not approved**
4. What is the indication or diagnosis?	☐ Locally advanced or metastatic non-small cell lung cancer - Proceed to question **5** ☐ Other diagnosis - Proceed to question **7**	
5. Does the patient have epidermal growth factor receptor exon 19 deletions or exon 21 L858R substitution mutation?	☐ Yes Proceed to question **6**	☐ No **Stop** **Coverage not approved**

6. Will the requested medication be prescribed in combination with amivantamab (Rybrevant)?	☐ Yes **Sign and date below**	☐ No **Stop** **Coverage not approved**
7. 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:**		_____ **Sign and date below**

Step 3

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

_____ _____
Prescriber Signature Date

[12 February 2025]