US Family Health Plan

Prior Authorization Request Form for

Tovorafenib (Ojemda)

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.

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. Was the requested medication prescribed by or in consultation with a hematologist OR oncologist?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Does the patient have pediatric low-grade glioma?	☐ Yes Proceed to question **3**	☐ No Proceed to question **5**
3. Does the patient have relapsed or refractory disease?	☐ Yes Proceed to question **4**	☐ No Proceed to question **5**
4. Is the tumor positive for one of the following: BRAF fusion, BRAF rearrangement, BRAF V600 mutation?	☐ Yes **Sign and date below**	☐ No 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. Please provide the diagnosis, guideline version and page number. Please note that the decision to approve, is subject to review of the information provided.	**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 _____

[13 November 2024]