

US Family Health Plan

Prior Authorization Request Form for

Alpelisib (Piqray)

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. Is the requested medication being prescribed by or in consultation with an oncologist /hematologist?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Is the patient GREATER THAN or EQUAL TO 18 years of age?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Has the patient been diagnosed with advanced or metastatic HR positive, HER2 negative breast cancer with PIK3CA mutation as confirmed by an FDA-approved test?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No Proceed to question 15
4. Is the patient female?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No Proceed to question 8
5. Is the patient post-menopausal or pre-menopausal?	<input type="checkbox"/> Post-menopausal Proceed to question 9	<input type="checkbox"/> Pre-menopausal Proceed to question 6
6. Is the patient receiving ovarian ablation/suppression?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved
7. Will the patient use effective contraception during therapy and for one week after the last dose?	<input type="checkbox"/> Yes Proceed to question 9	<input type="checkbox"/> No STOP Coverage not approved

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8. Will the patient use condoms and effective contraception during therapy and for one week after last dose?	<input type="checkbox"/> Yes Proceed to question 9	<input type="checkbox"/> No STOP Coverage not approved
9. Has the patient tried and failed, or is not a candidate for, adjuvant or neoadjuvant chemotherapy?	<input type="checkbox"/> Yes Proceed to question 10	<input type="checkbox"/> No STOP Coverage not approved
10. Has the patient had disease progression while on or after endocrine-based therapy?	<input type="checkbox"/> Yes Proceed to question 11	<input type="checkbox"/> No STOP Coverage not approved
11. Will the patient receive fulvestrant injection (Faslodex) therapy along with alpelisib (Piqray)?	<input type="checkbox"/> Yes Proceed to question 12	<input type="checkbox"/> No STOP Coverage not approved
12. Does the patient have a history of Stevens Johnson Syndrome, Erythema Multiforme, or Toxic Epidermal Necrolysis?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 13
13. Is the provider aware and has informed patient of risk of serious, life-threatening skin reactions, including Stevens Johnson Syndrome; severe hyperglycemia; gastrointestinal toxicity, including severe diarrhea; kidney injury; lung injury including pneumonitis; pancreatitis; and severe hypersensitivity reactions?	<input type="checkbox"/> Yes Proceed to question 14	<input type="checkbox"/> No STOP Coverage not approved
14. Is the provider aware and has informed the patient that safety has not been established in type 1 or uncontrolled type 2 diabetic patients?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
15. Please provide the diagnosis.	_____ Proceed to question 16	
16. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> 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