USFHP 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

https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Clinical documentation may be required. 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 being prescribed by or in consultation with an oncologist /hematologist?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the patient GREATER THAN or EQUAL TO 18 years of age?	☐ Yes Proceed to question **3**	☐ 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?	☐ Yes Proceed to question **4**	☐ No Proceed to question **13**
4. Is the patient female?	☐ Yes Proceed to question **5**	☐ No Proceed to question **6**
5. Will the patient use effective contraception during therapy and for one week after the last dose?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

6. Will the patient use condoms and effective contraception during therapy and for one week after last dose?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Has the patient tried and failed, or is not a candidate for, adjuvant or neoadjuvant chemotherapy?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Has the patient had disease progression while on or after endocrine-based therapy?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Will the patient receive fulvestrant injection (Faslodex) therapy along with alpelisib (Piqray)?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Does the patient have a history of Stevens Johnson Syndrome, Erythema Multiforme, or Toxic Epidermal Necrolysis?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **11**
11. 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?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Is the provider aware and has informed the patient that safety has not been established in type 1 or uncontrolled type 2 diabetic patients?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
13. Please provide the diagnosis.	_____ Proceed to question **14**	
14. 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 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date