US Family Health Plan
Prior Authorization Request Form for
Selpercatinib (Retevmo)

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 review.
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. What is the indication or diagnosis?	☐ Metastatic RET fusion-positive non-small cell lung cancer (NSCLC) - Proceed to question **7** ☐ Advanced or metastatic RET-mutant medullary thyroid cancer (MTC) who require systemic therapy - Proceed to question **4** ☐ Advanced or metastatic RET fusion-positive thyroid cancer who require systemic therapy - Proceed to question **3** ☐ Locally advanced or metastatic solid tumors with a RET gene fusion - Proceed to question **5** ☐ Other - Proceed to question **8**	
3. Is the patient refractory to radioactive iodine (if radioactive iodine is appropriate)?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the patient 12 years of age or older?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
5. Has the patient progressed on or following prior systemic treatment?	☐ Yes Proceed to question **7**	☐ No Proceed to question **6**

6. Does the patient have satisfactory alternative treatment options?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **7**
7. Is the patient 18 years of age or older?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
8. Please provide the indication or diagnosis.	_____ Proceed to question **9**	
9. Is the diagnosis from question 6 cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Will the patient be monitored for hepatotoxicity and QT prolongation?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Does the patient have uncontrolled hypertension?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **12**
12. Is the provider aware and has counseled the patient that selpercatinib can cause life-threatening hemorrhage and allergic reactions?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Is the patient of childbearing potential?	☐ Yes Proceed to question **14**	☐ No **Sign and date below**
14. What is the patient's gender?	☐ Male – Proceed to question **15** ☐ Female – Proceed to question **16**	
15. Will the patient use effective contraception during treatment and for at least 1 week after the cessation of therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
16. Will the patient use effective contraception during treatment and for at least 1 week after the cessation of therapy?	☐ Yes Proceed to question **17**	☐ No **STOP** **Coverage not approved**
17. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **18**
18. Has it been confirmed that the patient is not pregnant by (-) HCG?	☐ Yes Proceed to question **19**	☐ No **STOP** **Coverage not approved**

	19. Will the patient not breastfeed during treatment and for at least 1 week after the cessation of treatment?	☐ 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 _____

[02 August 2023]