US Family Health Plan

Prior Authorization Request Form for

Entrectinib (Rozlytrek)

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**

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?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Does the patient have a diagnosis of ROS1 positive Metastatic non-small-cell lung carcinoma (NSCLC)?	☐ Yes Proceed to question **6**	☐ No Proceed to question **3**
3. Does the patient have a diagnosis of a solid tumor that meets all three of the following criteria: • **has a neurotrophic tropomyosin receptor kinase (NTRK) gene fusion without a known acquired resistance mutation, and** • **is metastatic OR where surgical resection is likely to result in severe morbidity, and** • **has no satisfactory alternative treatments OR that has progressed following such treatment(s).**	☐ Yes Proceed to question **6**	☐ No Proceed to question **4**
4. Please provide the diagnosis.	_____ 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. Has the patient had a recent evaluation of their left ventricle including ejection fraction?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Does the patient have decompensated congestive heart failure (CHF)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **8**
8. Has the patient had a recent uric acid level?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Is the provider aware and has informed the patient of the risk of CHF development and exacerbation, myocarditis, neurotoxicity, fracture risk, hepatotoxicity, hyperuricemia, QT-prolongation, permanent visual impairment, and embryo-fetal toxicity?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Is the patient of reproductive potential?	☐ Yes Proceed to question **11**	☐ No **Sign and date below**
11. What is the patient's age/gender?	☐ Male - Proceed to question **15** ☐ Female – Proceed to question **12**	
12. Is the patient female and breastfeeding?	☐ Yes Proceed to question **13**	☐ No Proceed to question **14**
13. Will the patient refrain from breastfeeding during treatment and for 1 week after cessation of treatment?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Will the patient use highly effective contraception during treatment and for at least 5 weeks after cessation of treatment?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
15. Will the patient use highly effective contraception during treatment and for at least 3 months after 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