

# US Family Health Prior Authorization Request Form for sotorasib (**Lumakras**)

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**

Medical documentation may be required. Failure to provide could result in denial

**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 patient <b>GREATER THAN</b> or <b>EQUAL</b> to 18 years of age?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
2. Is the requested drug being prescribed by or in consultation with a hematologist/oncologist?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
3. Does the patient have <b>KRAS G12C-mutated locally advanced or metastatic non-small cell lung cancer (NSCLC)</b> , as determined by an FDA-approved test?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No Proceed to question 4
4. What is the diagnosis or indication for use?  _____	Proceed to question 5	
5. Is the diagnosis cited in the <b>National Comprehensive Cancer Network (NCCN) guidelines</b> as a category 1, 2A, or 2B recommendation?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
6. Will the patient be monitored for interstitial lung disease and hepatotoxicity?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
7. What is the patient's gender?	<input type="checkbox"/> Female Proceed to question 8	<input type="checkbox"/> Male <b>Sign and date below</b>

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8. Will the patient avoid breastfeeding during treatment and for at least 1 week after the cessation of treatment?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
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**Step 3** I certify the above is true to the best of my knowledge. Please sign and date:

\_\_\_\_\_

Prescriber Signature

\_\_\_\_\_

Date

[02 March 2022]