US Family Health Plan

Prior Authorization Request Form for

# Tucatinib (Tukysa)

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:**

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|---|---|---|---|
| 1. | **Is the patient 18 years of age or older?** | ☐ Yes<br>Proceed to question **2** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **2.** | **Is the requested medication prescribed by or in consultation with a hematologist or oncologist?** | ☐ Yes<br>Proceed to question **3** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **3.** | **Does the patient have a confirmed diagnosis of unresectable or metastatic HER2-positive breast cancer (including patients with brain metastases)?** | ☐ Yes<br>Proceed to question **4** | ☐ No<br>Proceed to question **5** |
| **4.** | **Has the patient received at least one prior anti-HER2-based regimen in the metastatic setting?** | ☐ Yes<br>Proceed to question **8** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **5.** | **Does the patient have a confirmed diagnosis of RAS wild-type, HER2-positive, unresectable, or metastatic colorectal cancer that has progressed following treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy?** | ☐ Yes<br>Proceed to question **9** | ☐ No<br>Proceed to question **6** |

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| **6. Please provide the indication or diagnosis.** | _____<br>Proceed to question **7** | |
| **7. Is the diagnosis from question 5 cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?** | ☐ Yes<br>Proceed to question **10** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **8. Will the requested medication be used in combination with trastuzumab (Herceptin) and capecitabine (Xeloda)?** | ☐ Yes<br>Proceed to question **10** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **9. Will the requested medication be used in combination with trastuzumab?** | ☐ Yes<br>Proceed to question **10** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **10. Will the provider monitor for hepatotoxicity?** | ☐ Yes<br>Proceed to question **11** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **11. Has the patient been counseled on risk of diarrhea?** | ☐ Yes<br>Proceed to question **12** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **12. Is the patient of childbearing potential?** | ☐ Yes<br>Proceed to question **13** | ☐ No<br>**Sign and date below** |
| **13. What is the patient's gender?** | ☐ Male – Proceed to question **14**<br>☐ Female – Proceed to question **15** | |
| **14. Will the patient use effective contraception during treatment and for at least 1 week after the cessation of therapy?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **15. Will the patient use effective contraception during treatment and for at least 1 week after the cessation of therapy?** | ☐ Yes<br>Proceed to question **16** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **16. Is the patient pregnant?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>Proceed to question **17** |

| | | |
|---|---|---|
| **17. Has it been confirmed that the patient is not pregnant by (-) HCG?** | ☐ Yes<br>Proceed to question **18** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **18. Will the patient not breastfeed during treatment and for at least 1 week after the cessation of treatment?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**STOP**<br>**Coverage not approved** |

**Step 3** **I certify the above is true to the best of my knowledge.**
Please sign and date:

Prescriber Signature _____ Date _____

[27 September 2023]