US Family Health Plan

Prior Authorization Request Form for

Belzutifan (Welireg)

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**

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 18 years of age or older?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication prescribed by or in consultation with an oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. What is the indication or diagnosis?	☐ von Hippel-Landau disease and requires therapy for associated renal cell carcinoma (RCC), CNS hemangioblastomas or pancreatic neuroendocrine tumors (pNET) not requiring surgery - Proceed to question **6** ☐ Advanced renal cell carcinoma (RCC) following a programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor and a vascular endothelial growth factor tyrosine kinase inhibitor (VEGF-TKI) - Proceed to question **6** ☐ Other - Proceed to question **4**	
4. Please provide the indication or diagnosis.	_____ Proceed to question **5**	

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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. Is the patient of childbearing potential?	☐ Yes Proceed to question **7**	☐ No **Sign and date below**
7. What is the patient's gender?	☐ Male – Proceed to question **8** ☐ Female – Proceed to question **10**	
8. Is the patient aware that Welireg may cause male infertility?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Will the patient use effective nonhormonal contraception during treatment and for at least 3 months after the cessation of therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
10. Will the patient use effective nonhormonal contraception during treatment and for at least 1 week after the cessation of therapy?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Has it been confirmed that the patient is not pregnant by (-) HCG?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Will the patient avoid breastfeeding during treatment and for at least 3 weeks 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