US Family Health Plan

Prior Authorization Request Form for

Crizotinib (Xalkori) capsules and pellets

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.
For patients UNDER 12 years of age, no prior authorization is required.

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 request medication being prescribed by or in consultation with a hematologist/oncologist?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. What is the indication or diagnosis?	☐ Metastatic non-small cell lung cancer (NSCLC) - Proceed to question **3** ☐ Relapsed or refractory systemic anaplastic large cell lymphoma (ALK) positive - Proceed to question **4** ☐ Unresectable, recurrent, or refractory inflammatory myofibroblastic tumor – Proceed to question **5** ☐ Other - Proceed to question **7**	
3. Is the NSCLC tumor anaplastic lymphoma kinase (ALK) positive or ROS1-positive (as detected by an FDA-approved test)?	☐ Yes Proceed to question **10**	☐ No **STOP** Coverage not approved
4. Is the patient 1 year of age and older or a young adult? (Note – limitation of use: safety and efficacy of Xalkori have not been established in older adults with relapsed or refractory systemic ALK-positive anaplastic large cell lymphoma)	☐ Yes Proceed to question **10**	☐ No **STOP** Coverage not approved
5. Is the patient greater than or equal to 1 year(s) of age?	☐ Yes Proceed to question **6**	☐ No **STOP** Coverage not approved

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6. Is the tumor anaplastic lymphoma kinase (ALK)-positive?	☐ Yes Proceed to question **10**	☐No STOP Coverage not approved
7. Please provide the diagnosis.	_____ Proceed to question **8**	
8. Is the diagnosis 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
9. What is the requested medication?	☐ crizotinib (Xalkori) oral pellets - Proceed to question **10** ☐ crizotinib (Xalkori) capsules - **Sign and date below**	
10. Please explain why the patient requires Xalkori oral pellets and cannot take Xalkori capsules.	_____ **Sign and date below**	

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

_____ _____
Prescriber Signature Date