TRICARE Prior Authorization Request Form for
avapritinib **(Ayvakit)**

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100, Hanover, MD 21076

Fax Completed Form and Applicable Progress Notes to:
(410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

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 GREATER THAN or EQUAL to 18 years of age?**	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication prescribed by or in consultation with a hematologist/oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Does the patient have pathologically confirmed unresectable or metastatic gastrointestinal stromal tumor (GIST) harboring a platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation with or without the D842V mutation?	☐ Yes Proceed to question **8**	☐ No Proceed to question **4**
4. Does the patient have advanced systemic mastocytosis (includes patients with aggressive systemic mastocytosis, systemic mastocytosis with an associated hematologic neoplasm, and mast cell leukemia)?	☐ Yes Proceed to question **8**	☐ No Proceed to question **5**
5. Does the patient have indolent systemic mastocytosis (ISM) with a platelet count GREATER THAN OR EQUAL TO 50 x 10^9/L?	☐ Yes Proceed to question **8**	☐ No Proceed to question **6**
6. Please provide the indication or diagnosis.	_____ Proceed to question **7**	

7. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Will the provider monitor for intracranial bleeding and other central nervous system (CNS) adverse effects?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. What is the patient's gender?	☐ Male – Proceed to question **10** ☐ Female – Proceed to question **11**	
10. Will the patient use effective contraception during treatment and for at least 6 weeks after the cessation of therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
11. Is the patient of childbearing potential?	☐ Yes Proceed to question **12**	☐ No **Sign and date below**
12. Will the patient use effective contraception during treatment and for at least 6 weeks after the cessation of therapy?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **14**
14. Has it been confirmed that the patient is not pregnant by (-) HCG?	☐ Yes Proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Will the patient breastfeed during treatment and for at least 2 weeks after the cessation of treatment?	☐ Yes **STOP** **Coverage not approved**	☐ No **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

[03 January 2024]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: