TRICARE Prior Authorization Request Form for
adagrasib **(Krazati)**

JOHNS HOPKINS
HEALTH PLANS

7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

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

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

Prior authorization does not expire.

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 drug being prescribed by or in consultation with a hematologist or oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. What is the indication or diagnosis?	☐ KRAS G12C-mutated locally advanced OR metastatic non-small cell lung cancer (NSCLC) **- Sign and date below** ☐ KRAS G12C-mutated locally advanced OR metastatic colorectal cancer (CRC) in combination with cetuximab, in patients who have received prior treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy **- Sign and date below** ☐ Other - Proceed to question **4**	

4. **The diagnosis IS NOT listed above but IS cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation. If so, please list the diagnosis:** **To facilitate approval, please list the diagnosis, guideline version and provide page number.**	______________________________ **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

[2 April 2025]

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