TRICARE Prior Authorization Request Form for
lazertinib **(Lazcluze)**

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 requested medication prescribed by or in consultation with a hematologist or oncologist?	☐ Yes Proceed to question **2**	☐ No **Stop** **Coverage not approved**
2. Is the patient greater 18 years of age or older?	☐ Yes Proceed to question **3**	☐ No **Stop** **Coverage not approved**
3. Will the patient be given prophylaxis for the prevention of venous thromboembolism during the first four months of treatment?	☐ Yes Proceed to question **4**	☐ No **Stop** **Coverage not approved**
4. What is the indication or diagnosis?	☐ Locally advanced or metastatic non-small cell lung cancer - Proceed to question **5** ☐ Other diagnosis - Proceed to question **7**	
5. Does the patient have epidermal growth factor receptor exon 19 deletions or exon 21 L858R substitution mutation?	☐ Yes Proceed to question **6**	☐ No **Stop** **Coverage not approved**

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6. Will the requested medication be prescribed in combination with amivantamab (Rybrevant)?	☐ Yes **Sign and date below**	☐ No **Stop** **Coverage not approved**
7. 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. **To facilitate approval, please list the diagnosis, guideline version, and 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

[12 February 2025]

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