TRICARE Prior Authorization Request Form for
futibatinib (Lytgobi)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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 being prescribed by or in consultation with a hematologist or oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Has the patient previously been treated for unresectable locally advanced or metastatic cholangiocarcinoma with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test?	☐ Yes Proceed to question **6**	☐ No Proceed to question **4**
4. What is the diagnosis or indication?	_____ Proceed to question **5**	
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. Will the patient be monitored for retinal pigment epithelial detachment, hyperphosphatemia, and soft-tissue mineralization?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

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7. Is the patient of childbearing potential?	☐ Yes Proceed to question **8**	☐ No **Sign and date below**
8. What is the patient's gender?	☐ Female Proceed to question **9**	☐ ale Proceed to question **12**
9. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **10**
10. Has it been confirmed that the patient is not pregnant by negative HCG (human chorionic gonadotropin)?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Will the patient avoid breastfeeding during treatment and for at least 1 week after the cessation of treatment?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Does the patient agree to use effective contraception during treatment and for at least 1 week after cessation of therapy?	☐ 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

[17 May 2023]

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