TRICARE Prior Authorization Request Form for
dasatinib (Phyrago)

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

USFHP Pharmacy Prior Authorization Form

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

Fax completed form and applicable progress notes to: (410) 424-4037

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

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

Prior authorization expires yearly. Initial TRICARE PA approval is required for renewal. Coverage will be approved for an additional year.

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. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication.*	☐Yes (subject to verification) Proceed to question **2**	☐No Proceed to question **3**
2. Does the patient have a documented reason to remain on concurrent H2 blockers or proton pump inhibitors (PPIs)?	☐Yes **Sign and date below**	☐No **STOP** **Coverage not approved**
3. Is the requested medication being prescribed by or in consultation with a hematologist or oncologist?	☐Yes Proceed to question **4**	☐No **STOP** **Coverage not approved**
4. How old is the patient?	☐1 to 17 years of age – Proceed to question **6** ☐18 years of age or older – Proceed to question **5** ☐Less than 1 year of age – **STOP – Coverage not approved**	
5. For adult patients, what is the indication or diagnosis?	☐Newly diagnosed Philadelphia chromosome-positive (Ph+) chronic myeloid leukemia (CML) in chronic phase - Proceed to question **7** ☐Ph+ CML who no longer benefit from, or did not tolerate, other treatment, including imatinib - Proceed to question **7** ☐Ph+ acute lymphoblastic leukemia (Ph+ ALL) who no longer benefit from, or did not tolerate, other treatment - Proceed to question **7** ☐Other diagnosis - Proceed to question **10**	

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6. For pediatric patients, what is the indication or diagnosis?	☐ Ph+ CML in chronic phase - Proceed to question **7** ☐ Newly diagnosed Ph+ ALL in combination with chemotherapy - Proceed to question **7** ☐ Other diagnosis - Proceed to question **10**	
7. Is the patient receiving concurrent H2 blockers (for example, famotidine, ranitidine, cimetidine) or Proton Pump Inhibitors (PPIs) (for example, omeprazole esomeprazole, rabeprazole, lansoprazole)?	☐ Yes Proceed to question **8**	☐ No Proceed to question **9**
8. Please document the reason why the patient requires long-term concurrent H2 blockers or proton pump inhibitors.	_____ **Sign and date below**	
9. Has the patient been referred to GI for additional work up (for example, endoscopy)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
10. 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

[11 March 2026]

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