

TRICARE Prior Authorization Request Form for
alpelisib (**Piqray**)



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 requested medication being prescribed by or in consultation with an oncologist /hematologist?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Is the patient GREATER THAN or EQUAL TO 18 years of age?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Has the patient been diagnosed with advanced or metastatic HR positive, HER2 negative breast cancer with PIK3CA mutation as confirmed by an FDA-approved test?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No Proceed to question 13
4. Is the patient female?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No Proceed to question 6
5. Will the patient use effective contraception during therapy and for one week after the last dose?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved

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6. Will the patient use condoms and effective contraception during therapy and for one week after last dose?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved
7. Has the patient tried and failed, or is not a candidate for, adjuvant or neoadjuvant chemotherapy?	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> No STOP Coverage not approved
8. Has the patient had disease progression while on or after endocrine-based therapy?	<input type="checkbox"/> Yes Proceed to question 9	<input type="checkbox"/> No STOP Coverage not approved
9. Will the patient receive fulvestrant injection (Faslodex) therapy along with alpelisib (Piqray)?	<input type="checkbox"/> Yes Proceed to question 10	<input type="checkbox"/> No STOP Coverage not approved
10. Does the patient have a history of Stevens Johnson Syndrome, Erythema Multiforme, or Toxic Epidermal Necrolysis?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 11
11. Is the provider aware and has informed patient of risk of serious, life-threatening skin reactions, including Stevens Johnson Syndrome; severe hyperglycemia; gastrointestinal toxicity, including severe diarrhea; kidney injury; lung injury including pneumonitis; pancreatitis; and severe hypersensitivity reactions?	<input type="checkbox"/> Yes Proceed to question 12	<input type="checkbox"/> No STOP Coverage not approved
12. Is the provider aware and has informed the patient that safety has not been established in type 1 or uncontrolled type 2 diabetic patients?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
13. Please provide the diagnosis.	<hr style="width: 80%; margin-left: auto; margin-right: 0;"/> Proceed to question 14	
14. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> 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

[02 October 2024]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: