TRICARE Prior Authorization Request Form for
fitusiran (Qfitlia)

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 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 12 years of age or older?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication being prescribed by or in consultation with a hematologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. What is the indication or diagnosis?	☐ Hemophilia A with or without factor VIII inhibitors - Proceed to question **4** ☐ Hemophilia B with or without factor IX inhibitors - Proceed to question **6** ☐ Other diagnosis - **STOP - Coverage not approved**	
4. Has the patient had an inadequate response or intolerance to emicizumab-kxwh (Hemlibra)?	☐ Yes Proceed to question **8**	☐ No Proceed to question **5**
5. Does the patient have a contraindication to emicizumab-kxwh (Hemlibra)?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
6. Has the patient had an inadequate response or intolerance to marstacimab-hncq (Hympavzi) or concizumab-mtci (Alhemo)?	☐ Yes Proceed to question **8**	☐ No Proceed to question **7**

7. Does the patient have a contraindication to marstacimab-hncq (Hympavzi) or concizumab-mtci (Alhemo)?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Will the patient concurrently receive Factor VIII or IX therapy after the initial transition period?	☐ Yes Proceed to question **9**	☐ No Proceed to question **10**
9. Is Factor VIII or IX therapy being used for the treatment of breakthrough bleeding?	☐ Yes Proceed to question 10	☐ No **STOP** **Coverage not approved**
10. Is the requested medication being used in combination with Immune Tolerance Induction (ITI)?	☐ Yes **STOP** **Coverage not approved**	☐ No **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

[15 July 2026]

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