TRICARE Prior Authorization Request Form for
remibrutinib (Rhapsido)

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 in 12 months. Renewal approvals do not expire. For renewal of therapy an initial Tricare prior authorization approval is required.

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 Rhapsido.*	☐ Yes (subject to verification) proceed to question **2**	☐ No Proceed to question **3**
2. Has the patient's disease severity improved and stabilized to warrant continued therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
3. Is the patient 18 years of age or older?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the requested medication being prescribed by an allergist, immunologist or dermatologist?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. What is the indication or diagnosis?	☐ Chronic spontaneous urticaria with symptoms lasting greater than 6 weeks - Proceed to question **6** ☐ Other diagnosis- **STOP- Coverage not approved**	
6. Does the patient remain symptomatic despite trial of AT LEAST 4 weeks with recommended second generation H1 antihistamine (such as, cetirizine, levocetirizine, loratadine, desloratadine, fexofenadine)?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

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7. Has the patient had an inadequate response to, intolerability to, or has a contraindication to Xolair?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Has the patient had an inadequate response to, intolerability to, or has a contraindication to Dupixent?	☐ 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

[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: