TRICARE Prior Authorization Request Form for
entrectinib (**Rozlytrek**)

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HEALTH PLANS
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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.

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 requested medication being prescribed by or in consultation with an oncologist?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Does the patient have a diagnosis of ROS1 positive Metastatic non-small-cell lung carcinoma (NSCLC)?	☐ Yes Proceed to question **6**	☐ No Proceed to question **3**
3. Does the patient have a diagnosis of a solid tumor that meets all three of the following criteria: • **has a neurotrophic tropomyosin receptor kinase (NTRK) gene fusion without a known acquired resistance mutation, and** • **is metastatic OR where surgical resection is likely to result in severe morbidity, and** • **has no satisfactory alternative treatments OR that has progressed following such treatment(s).**	☐ Yes Proceed to question **6**	☐ No Proceed to question **4**
4. Please provide the diagnosis.	_____ 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**

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6. Has the patient had a recent evaluation of their left ventricle including ejection fraction?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Does the patient have decompensated congestive heart failure (CHF)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **8**
8. Has the patient had a recent uric acid level?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Is the provider aware and has informed the patient of the risk of CHF development and exacerbation, myocarditis, neurotoxicity, fracture risk, hepatotoxicity, hyperuricemia, QT-prolongation, permanent visual impairment, and embryo-fetal toxicity?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Is the patient of reproductive potential?	☐ Yes Proceed to question **11**	☐ No **Sign and date below**
11. What is the patient's age/gender?	☐ Male - Proceed to question **15** ☐ Female – Proceed to question **12**	
12. Is the patient female and breastfeeding?	☐ Yes Proceed to question **13**	☐ No Proceed to question **14**
13. Will the patient refrain from breastfeeding during treatment and for 1 week after cessation of treatment?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Will the patient use highly effective contraception during treatment and for at least 5 weeks after cessation of treatment?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
15. Will the patient use highly effective contraception during treatment and for at least 3 months after cessation of treatment?	☐ 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

[29 May 2024]

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