TRICARE Prior Authorization Request Form for
quizartinib tab (**Vanflyta**)

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 patient GREATER THAN or EQUAL to 18 years of age?**	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. **Is the requested medication prescribed by or in consultation with a hematologist or oncologist?**	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. **What is the indication?**	☐ acute myeloid leukemia (AML) Proceed to question **4**	☐ Other Proceed to question **5**
4. **Does the patient have newly diagnosed acute myeloid leukemia (AML) that is tyrosine kinase 3 (FLT3) internal tandem duplication (ITD)-positive as detected by an FDA-approved test?**	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
5. **Please provide the indication or diagnosis.**	_____ Proceed to question **6**	
6. **Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?**	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

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7. Is the provider aware of all warnings, monitoring and screening precautions for Vanflyta?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Is the provider certified to prescribe Vanflyta per REMS requirements?	☐ 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 _____

[14 February 2024]

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