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

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

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.

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 Vijoice.*	☐ Yes (subject to verification) Proceed to question **2**	☐ No Proceed to question **3**
2. Does the patient have a documented positive clinical response to therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
3. Is the prescription written by or in consultation with a medical geneticist or vascular surgeon?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient have a documented diagnosis of PIK3CA Related Overgrowth Spectrum (PROS) which the provider determines to be severe and requiring systemic therapy?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have a documented evidence of a mutation in the PIK3CA gene?	☐ 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

[09 November 2022]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#: