Prior Authorization Request Form for
larotrectinib (**Vitrakvi**) capsules and oral solution

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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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.

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 this medication being prescribed by or in consultation with a hematologist or oncologist?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. For which indication is the requested medication being prescribed?	☐ Solid tumor – proceed to question **3** ☐ Advanced metastatic non-small cell lung cancer (NSCLC) – proceed to question **5** ☐ Other – proceed to question **6**	
3. Is the solid tumor metastatic or would surgical resection result in severe morbidity?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Has the solid tumor progressed despite alternative treatment or there are no satisfactory alternative treatments?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. Does the tumor have neurotropic tropomysin receptor kinase (NTRK) gene fusion without a known acquired resistance mutation?	☐ Yes Proceed to question **8**	☐ No **STOP** Coverage not approved
6. Please provide the diagnosis.	_____ Proceed to question **7**	
7. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **8**	☐ No **STOP** Coverage not approved

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8. Is the patient of reproductive age?	☐ Yes Proceed to question **9**	☐ No Proceed to question **10**
9. Will the patients (males and females) of reproductive potential use effective contraception during treatment and for at least 1 week after discontinuation?	☐ Yes Proceed to question **10**	☐ No **STOP** Coverage not approved
10. Is the patient a female?	☐ Yes Proceed to question **11**	☐ No Proceed to question **12**
11. Has it been confirmed that the patient will not breastfeed during treatment and for 1 week after cessation of treatment?	☐ Yes Proceed to question **12**	☐ No **STOP** Coverage not approved
12. Which formulation is being requested?	☐ **Capsules** - **Sign and date below** ☐ **Oral solution** - Proceed to question **13**	
13. Does the patient have difficulty swallowing the capsules?	☐ 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 _____

[08 April 2020]

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