TRICARE Prior Authorization Request Form for
**rilzabrutinib (Wayrilz)**

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.

**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 patient 18 years of age or older?** | ☐ Yes<br>Proceed to Question **2** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **2. Has the patient had primary Immune Thrombocytopenic Purpura (ITP) for at least 3 months?** | ☐ Yes<br>Proceed to Question **3** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **3. Is the requested medication being prescribed by a hematologist or oncologist?** | ☐ Yes<br>Proceed to Question **4** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **4. Has the patient had 2 platelet counts of LESS THAN 30 × 10^9/L AT LEAST 5 days apart?** | ☐ Yes<br>Proceed to Question **5** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **5. Does the patient have documented intolerance, insufficient response, OR any contraindication to any other ITP therapy?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**STOP**<br>**Coverage not approved** |

**Step 3** **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[12 September 2025]

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