TRICARE Prior Authorization Request Form for (crizotinib) **Xalkori capsules, pellets**

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.
For patients UNDER 12 years of age, no prior authorization is required.

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 request medication being prescribed by or in consultation with a hematologist/oncologist?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. What is the indication or diagnosis?	☐ Metastatic non-small cell lung cancer (NSCLC) - Proceed to question **3** ☐ Relapsed or refractory systemic anaplastic large cell lymphoma (ALK) positive - Proceed to question **4** ☐ Unresectable, recurrent, or refractory inflammatory myofibroblastic tumor – Proceed to question **5** ☐ Other - Proceed to question **7**	
3. Is the NSCLC tumor anaplastic lymphoma kinase (ALK) positive or ROS1-positive (as detected by an FDA-approved test)?	☐ Yes Proceed to question **10**	☐ No **STOP** Coverage not approved
4. Is the patient 1 year of age and older or a young adult? (Note – limitation of use: safety and efficacy of Xalkori have not been established in older adults with relapsed or refractory systemic ALK-positive anaplastic large cell lymphoma)	☐ Yes Proceed to question **10**	☐ No **STOP** Coverage not approved
5. Is the patient greater than or equal to 1 year(s) of age?	☐ Yes Proceed to question **6**	☐ No **STOP** Coverage not approved

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6. Is the tumor anaplastic lymphoma kinase (ALK)-positive?	☐ Yes Proceed to question **10**	☐No STOP Coverage not approved
7. Please provide the diagnosis.	_____ Proceed to question **8**	
8. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **10**	☐ No **STOP** Coverage not approved
9. What is the requested medication?	☐ crizotinib (Xalkori) oral pellets - Proceed to question **10** ☐ crizotinib (Xalkori) capsules - **Sign and date below**	
10. Please explain why the patient requires Xalkori oral pellets and cannot take Xalkori capsules.	_____ **Sign and date below**	

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

_____ _____
Prescriber Signature Date

[08 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: