TRICARE Prior Authorization Request Form for
bosutinib capsules (Bosulif)

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 requested drug being prescribed by or in consultation with a hematologist/oncologist?	☐ Yes **Proceed to question 2**	☐ No **STOP** **Coverage not approved**
2. How old is the patient?	☐ Less than or equal to 1 years of age – **STOP Coverage not approved** ☐ Greater than or equal to 1 years of age and Less than or equal to 17 years of age - **Proceed to question 3** ☐ Greater than or equal to 18 years of age - **Proceed to question 4**	
3. What is the diagnosis or indication?	☐ Newly diagnosed Chronic phase Philadelphia chromosome-positive (Ph+) chronic myelogenous leukemia – **Sign and date below** ☐ Ph+ chronic myelogenous leukemia that is resistant to prior therapy - **Sign and date below** ☐ Ph+ chronic myelogenous leukemia that is intolerant to prior therapy - **Sign and date below** ☐ Other - **Proceed to question 5**	
4. What is the diagnosis or indication?	☐ Accelerated or blast phase Ph+ chronic myeloid leukemia that is resistant to prior therapy - **Proceed to question 7** ☐ Accelerated or blast phase Ph+ chronic myeloid leukemia that is intolerant to prior therapy - **Proceed to question 7** ☐ Other - **Proceed to question 5**	

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5. Please provide the 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**
7. Is the patient unable to swallow tablets due to a documented medical condition (for example, dysphagia)?	☐ Yes **Proceed to question 8**	☐ No **STOP** **Coverage not approved**
8. Does the prescriber confirm that they are aware of all warnings, screening, and monitoring precautions for Bosulif?	☐ 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 August 2024]

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