TRICARE Prior Authorization Request Form for
methotrexate **(Jylamvo, Xatmep)** oral solution

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.

PA criteria does not apply to children 12 years of age and younger.

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. What is the requested medication?	☐ Jylamvo - Proceed to question **2** ☐ Xatmep - Proceed to question **3**	
2. Does the patient have acute lymphoblastic leukemia (ALL), mycosis fungoides, relapsed or refractory non-Hodgkin lymphoma, rheumatoid arthritis, severe psoriasis, or active polyarticular juvenile idiopathic arthritis?	☐ Yes Proceed to question **4**	☐ No Proceed to question **5**
3. Does the patient have a diagnosis of acute lymphoblastic leukemia (ALL) or active polyarticular juvenile idiopathic arthritis (pJIA)?	☐ Yes Proceed to question **4**	☐ No Proceed to question **5**
4. Does the patient have a history of difficulty swallowing tablets or has a medical condition that is characterized by difficulty swallowing or inability to swallow?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
5. Please provide the diagnosis.	_____ Proceed to question **6**	
6. Does the patient have a history of difficulty swallowing tablets or has a medical condition that is characterized by difficulty swallowing or inability to swallow?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

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

Prescriber Signature _____ Date _____

[8 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: