TRICARE Prior Authorization Request Form for
capivasertib **(Truqap)**

JOHNS HOPKINS
HEALTH PLANS
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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.

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 greater than or equal to 18 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Is the requested medication prescribed by or in consultation with a hematologist or oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. What is the indication or diagnosis?	☐ Advanced or metastatic HR-positive, HER2-negative breast cancer - Proceed to question **4** ☐ Other - Proceed to question **8**	
4. Does the patient have PIK3CA/AKT1/PTEN-alterations as detected by an FDA-approved test?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. Has the patient tried and failed, or is not a candidate for, adjuvant or neoadjuvant chemotherapy?	☐ Yes Proceed to question **6**	☐ No **STOP** Coverage not approved

6. Has the patient had disease progression while on or after endocrine therapy?	☐ Yes Proceed to question **7**	☐ No **STOP** Coverage not approved
7. Will the patient be receiving fulvestrant injection (Faslodex) therapy along with capivasertib (Truqap)?	☐ Yes Proceed to question **10**	☐ No **STOP** Coverage not approved
8. Please provide the diagnosis.	_____ Proceed to question **9**	
9. 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
10. Is the provider aware of all monitoring requirements and screening precautions?	☐ 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

[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: