TRICARE Prior Authorization Request Form for belzutifan (Welireg)

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.

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 Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication prescribed by or in consultation with an oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. What is the indication or diagnosis?	☐ von Hippel-Landau disease and requires therapy for associated renal cell carcinoma (RCC), CNS hemangioblastomas or pancreatic neuroendocrine tumors (pNET) not requiring surgery - Proceed to question **6** ☐ Advanced renal cell carcinoma (RCC) following a programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor and a vascular endothelial growth factor tyrosine kinase inhibitor (VEGF-TKI) - Proceed to question **6** ☐ Other - Proceed to question **4**	
4. Please provide the indication or diagnosis.	______________________ Proceed to question **5**	

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5. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Is the patient of childbearing potential?	☐ Yes Proceed to question **7**	☐ No **Sign and date below**
7. What is the patient's gender?	☐ Male – Proceed to question **8** ☐ Female – Proceed to question **10**	
8. Is the patient aware that Welireg may cause male infertility?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Will the patient use effective nonhormonal contraception during treatment and for at least 3 months after the cessation of therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
10. Will the patient use effective nonhormonal contraception during treatment and for at least 1 week after the cessation of therapy?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Has it been confirmed that the patient is not pregnant by (-) HCG?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Will the patient avoid breastfeeding during treatment and for at least 3 weeks after the cessation of treatment?	☐ 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

[29 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: