US Family Health Plan

Prior Authorization Request Form for

Brand Name Over Generic

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **855-273-5735**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

usfamilyhealth.org/rx-pa

Step 1 **Please complete patient and physician information** (Please Print)

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Please indicate which medication is being prescribed: _____

Step 2 **Please consider the following:**

- 32 CFR 199.21 (j)(2) Use of generic drugs under the pharmacy benefits program. The pharmacy benefits program generally requires mandatory substitution of generic drugs listed with an "A" rating in the current Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book) published by the FDA and generic equivalents of grandfather or Drug Efficacy Study Implementation (DESI) category drugs for brand name drugs. In cases in which there is a clinical justification for a brand name drug in lieu of a generic equivalent, under the standards and procedures of paragraph (h)(3) of this section, the generic substitution policy is waived.
- The generic products are A-rated by the Food and Drug Administration for bioequivalence and therapeutic equivalence to the brand name product. An A-rated product will produce comparable absorption and blood levels to the brand name product. It is the judgment of the FDA that based on its determination of therapeutic equivalence between generic and innovator drug products, "products evaluated as therapeutically equivalent can be expected to have equivalent clinical effect whether the product is brand name or generic drug product."

1. Has the patient tried the generic product?	☐ Yes **Proceed to Question 2**	☐ No **Proceed to Question 4**
2. Did the patient experience a significant adverse reaction to the generic?	☐ Yes **Proceed to Question 3**	☐ No **Proceed to Question 3**
3. Please provide an explanation of the patient's experience with the generic, then proceed to Step 3:		
4. Please provide patient-specific clinical justification as to why the A-rated generic product cannot be used, then proceed to Step 3:		

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

_____ Prescriber Signature

_____ Date

[5 May 2018]