US Family Health Plan
Prior Authorization Request Form for
flurandrenolide 4 mcg/sq.cm (**Cordran**) tape

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**

Prior authorization expires after 30 days.

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 medication being prescribed by a dermatologist or plastic surgeon?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Provider acknowledges that this agent has been identified as having cost-effective alternatives, including clobetasol propionate 0.05% ointment and fluocinonide 0.05% cream and fluocinonide 0.05% solution. These agents do not require a PA.	Proceed to question **3**	
3. Provider acknowledges that barrier function can be accomplished by using an alternative agent (for example, fluocinonide 0.05% cream) with an occlusive dressing. Please note occlusion increases transmission (i.e., potency); a lower potency agent should be used as an alternative to flurandrenolide tape if used with a barrier.	Proceed to question **4**	
4. Has the patient tried for at least 2 weeks and failed, have a contraindication to, or has had an adverse reaction to clobetasol propionate 0.05% ointment OR halobetasol propionate 0.05% ointment OR betamethasone dipropionate 0.05% ointment?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**

5. Please describe why Cordran tape is required as opposed to available alternatives.

Sign and date below

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

Prescriber Signature _____ Date _____

[4 March 2020]