

**US Family Health Plan
Prior Authorization Request Form for
Cycloset (bromocriptine)**

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 **617-562-5296**

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**

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. Does the patient have a confirmed diagnosis of type 2 diabetes mellitus?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Has the patient experienced any of the following adverse events while receiving metformin: impaired renal function that precludes treatment with metformin or a history of lactic acidosis?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 3
3. Has the patient experienced the following adverse event while receiving a sulfonylurea: hypoglycemia requiring medical treatment?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 4
4. Does the patient have a contraindication to BOTH metformin and a sulfonylurea?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 5
5. Has the patient tried BOTH of the following and failed to achieve glycemic control: METFORMIN (alone or in a combination product) and a SULFONYLUREA (alone or in a combination product)?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Coverage not approved

Step 3 I certify the above is true to the best of my knowledge.

Please sign and date:

Prescriber Signature

Date