

**US Family Health Plan
Prior Authorization Request Form for
penciclovir cream 1% (Denavir)**

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

Step 2 Please complete the clinical assessment:

1. Is the indication for use treatment of immunocompetent patients 12 years and older with recurrent herpes labialis?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Please explain why the patient requires Denavir and cannot take oral antivirals AND cannot use acyclovir 5% cream.		

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

_____ Prescriber Signature	_____ Date
-------------------------------	---------------