

US Family Health Plan  
Prior Authorization Request Form for  
duloxetine delayed-release capsules (**Drizalma Sprinkle**)

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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**

**Prior authorization approval expires after 1 year. No prior authorization required for patients 12 years of age and younger.**

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**Step 1** Please complete patient and physician information (please print):

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

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**Step 2** Please complete the clinical assessment:

<b>1. Please explain why the patient requires duloxetine sprinkle capsules and cannot take alternatives.</b>	
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**Step 3** I certify the above is true to the best of my knowledge. Please sign and date:

\_\_\_\_\_

Prescriber Signature

\_\_\_\_\_

Date

[19 February 2020]