US Family Health Plan
Prior Authorization Request Form for
metoprolol succinate ER capsules (**Kapspargo Sprinkle**)

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**

For patients UNDER 18 years of age, no prior authorization is required.

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 patient greater than 18 years of age?	☐ Yes Proceed to question 2	☐ No **STOP** **Prior Authorization Not Required**
2. Does the patient have a diagnosis of hypertension, angina pectoris, or heart failure?	☐ Yes Proceed to question 3	☐ No **STOP** **Coverage not approved**
3. Will the requested medication be dosed more often than once daily?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question 4
4. Please provide a patient-specific justification as to why the patient requires metoprolol succinate sprinkle and cannot take alternative formulary beta blockers.	Fill in the blank: **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 _____

[6 March 2019]