US Family Health Plan
Prior Authorization Form for
Levorphanol (Levo-Dromoran)

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. What is the **indication or diagnosis**?		
2. Is there a **contraindication** to the use of another drug from the same drug class as the requested drug or to a drug that is used for the same indication?	☐ Yes Proceed to question 3	☐ No Proceed to question 4
3. What is the reason other drugs are contraindicated?	Proceed to question 4	
4. Has the patient **experienced significant adverse effects** with use of other drugs from the same drug class as the requested drug or with drugs that are used for the same indication?	☐ Yes Proceed to question 5	☐ No Proceed to question 6
5. What other drugs have been tried and what adverse effects did the patient experience?	Proceed to question 6	
6. Has the patient **experienced therapeutic failure** with use of other drugs from the same drug class as the requested drug or with drugs that are used for the same indication?	☐ Yes Proceed to question 7 on next page	☐ No Proceed to question 8 on next page

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7. What other drugs have been tried and what was the outcome with their use?	Proceed to question 8		
8. Is there an **alternative drug that could be used in this patient,** either from the same drug class as the requested drug or a drug that is used for the same indication?		☐ Yes Sign and date below	☐ No Proceed to question 9
9. What is the reason or explanation for stating there are no alternative drugs that could be used in this patient?	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]