US Family Health Plan
Prior Authorization Request Form for
Tapentadol ER (**Nucynta ER**)

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 855-273-5735

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. This agent has been identified as having cost-effective alternatives including the following: tapentadol IR, gabapentin, tramadol and several other immediate release opioids. These agents are available without a PA. Please consider changing the prescription to one of these agents.	**proceed to question 2**	
2. Is the patient 18 years of age or older?	☐ Yes **Proceed to question 3**	☐ No **STOP** **Coverage not approved**
3. For which diagnosis is the requested medication being prescribed?	☐ Pain severe enough to require daily, around-the-clock, long-term opioid treatment - **Proceed to question 4** ☐ Neuropathic pain associated with diabetic peripheral neuropathy in adults severe enough to require daily, around-the-clock, long-term opioid treatment - **Proceed to question 5** ☐ Other indication or diagnosis- **STOP- Coverage not approved**	
4. Has the patient tried and failed at least ONE of the following short-acting opioids: morphine sulfate IR, codeine IR, hydromorphone IR, meperidine IR, oxycodone IR, hydrocodone/acetaminophen, oxycodone/acetaminophen, codeine/acetaminophen, tapentadol IR?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
5. Has the patient tried and failed, or had a contraindication to at least TWO of the following classes of non-opioid medications (unless the patient has a contraindication): • **gabapentin or pregabalin titrated to therapeutic dose,** • **tricyclic antidepressant titrated to therapeutic dose, or** • **duloxetine titrated to therapeutic dose?**	☐ Yes **Proceed to question 6**	☐ No **STOP** **Coverage not approved**

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6. Has the patient tried and failed Tramadol?	☐ Yes **Proceed to question 7**	☐ No **STOP** **Coverage not approved**
7. Has the patient tried and failed at least ONE of the following short acting opioids: morphine sulfate IR, codeine IR, hydromorphone IR, meperidine IR, oxycodone IR, hydrocodone/acetaminophen, oxycodone/acetaminophen, codeine/acetaminophen, tapentadol IR?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

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

Prescriber Signature _____ Date _____

[03 Mar 2021]