US Family Health Plan

Prior Authorization Request Form for

empagliflozin/ metformin (Synjardy/Synjardy XR)

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.

MAIL ORDER	**If the prescription is to be filled through the USFHP Mail Order Pharmacy, check here** ☐ • The completed form may be **faxed** to **1-617-562-5296** OR • The patient may attach the completed form to the prescription and **mail** it to: **Attn: Pharmacy, 77 Warren St, Brighton, MA 02135**	RETAIL	**If the prescription is to be filled at a retail pharmacy, check here** ☐ • The provider may **call 1-877-880-7007** OR • The completed form may be **faxed** to **617-562-5296**

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:**

Question	Yes	No
1. Has the patient had an inadequate response to metformin?	☐ 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 November 2017]