

US Family Health Plan
Prior Authorization Request Form for
Topical Acne and Rosacea Agents: Miscellaneous Topical Agents

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 expires after one year.

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

1	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 18 years of age or older?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. What medication is being requested?	<input type="checkbox"/> Rhofade Proceed to question 3	<input type="checkbox"/> Soolantra Proceed to question 4
3. Does the patient have non-transient, persistent facial erythema of rosacea?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
4. Does the patient have inflammatory lesions (papulopustular) of rosacea caused by Demodex mites?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
5. Has the patient tried and failed one generic preferred formulary topical metronidazole product (1% gel, 0.75% lotion, or 0.75% cream)?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No STOP Coverage not approved
6. Has the patient tried and failed topical azelaic acid?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> 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