US Family Health Plan
Prior Authorization Request Form for
Insulin degludec **(Tresiba)**

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. Is the patient greater than or equal to 1 year of age?	☐ **Yes** **Proceed to question 2**	☐ **No** **STOP** **Coverage not approved**
2. Please explain why the patient cannot use Lantus.	Fill in the blank: **Proceed to question 3**	
3. Please explain why the patient cannot use Toujeo.	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]