

US Family Health Plan
 Prior Authorization Request Form for
V-Go Disposable Insulin Delivery Device

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. Does the patient have a diagnosis of type 2 diabetes mellitus?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Does the patient require approximately 40 units or less of BASAL insulin daily?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Does the patient require approximately 36 units or less of BOLUS insulin daily?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
4. Does the patient require bolus insulin dosing in increments of 2 units per bolus? (that is, does the patient require bolus doses of 2 units, or 4 units, or 6 units, and so on?)	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
5. Has the patient been maintained on stable basal insulin for at least 3 months at dosages ranging from 20 units to 40 units per day?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No STOP Coverage not approved
6. Has the patient been using mealtime insulin for at least 3 months?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Coverage not approved

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature	Date
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