

US Family Health Plan

Prior Authorization Request Form for telotristat (Xermelo)

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

Prior authorization expires after one year. For renewal of therapy an initial Tricare prior authorization approval is required.

usfamilyhealth.org/rx-pa

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

<p>1 Patient Name: _____</p> <p>Address: _____</p> <p>Sponsor ID # _____</p> <p>Date of Birth: _____</p>	<p>Physician Name: _____</p> <p>Address: _____</p> <p>Phone #: _____</p> <p>Secure Fax #: _____</p>
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Step 2 Please complete the clinical assessment:

<p>2 1. Has the patient received this medication under the TRICARE benefit in the last 6 months? <i>Please choose "No" if the patient did not previously have a TRICARE approved PA for Xermelo</i></p>	<input type="checkbox"/> Yes (subject to verification) Proceed to question 3	<input type="checkbox"/> No Proceed to question 2
<p>2. Does the patient have a diagnosis of carcinoid syndrome diarrhea?</p>	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
<p>3. Has the patient had a decrease from baseline in the amount of average daily bowel movements?</p>	<input type="checkbox"/> Yes proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
<p>4. Does the prescriber agree to continue to assess the patient for severe constipation and abdominal pain and discontinue the medication if either develops?</p>	<input type="checkbox"/> Yes proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
<p>5. While taking Xermelo (telotristat) has the patient had severe constipation or has abdominal pain developed?</p>	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Sign and date below

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

<p>3 _____</p> <p style="text-align: center;">Prescriber Signature</p>	<p>_____</p> <p style="text-align: center;">Date</p>
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