US Family Health Plan
Prior Authorization Request Form for
ferric maltol **(Accrufer)**

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**

Initial and renewal prior authorization expires after 6 months. For renewal of therapy, an initial USFHP prior authorization approval is required.

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. Has the patient received this medication under the USFHP benefit in the last 6 months? *Please choose "No" if the patient did not previously have a USFHP approved PA for Accrufer.*	☐ Yes (subject to verification) **Proceed to question 2**	☐ No **Proceed to question 4**
2. Is the patient still iron deficient?	☐ Yes **Proceed to question 3**	☐ No **STOP Coverage not approved**
3. Has there been clinically significant improvement in the patient's iron deficiency? Please Note: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.	☐ Yes **Sign and date below**	☐ No **STOP Coverage not approved**
4. Does the patient have a documented diagnosis of iron deficiency?	☐ Yes **Proceed to question 5**	☐ No **STOP Coverage not approved**
5. Is the patient 18 years of age or older?	☐ Yes **Proceed to question 6**	☐ No **STOP Coverage not approved**
6. Has the patient tried and failed two oral iron products (must be different salts) of at least six weeks in duration for each?	☐ Yes **Proceed to question 8**	☐ No **Proceed to question 7**

7. Has the patient had a contraindication to or experienced clinically significant adverse effects to two oral iron products (must be different salts)?	☐ Yes **Proceed to question 8**	☐ No **STOP** **Coverage not approved**

8. Please provide the date of when the patient previously tried each medication, or the contraindication or clinically significant adverse effect that the patient experienced from each medication.

Note: The dates for each medication, or the contraindication or clinically significant adverse effect for each medication must be provided or your case could be denied.

Oral iron product: _____ Date of trial and failure: _____

Contraindication to medication or clinically significant adverse effect: _____

Oral iron product: _____ Date of trial and failure: _____

Contraindication to medication or clinically significant adverse effect: _____

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