

US Family Health Plan
Prior Authorization Request Form for
Vamorolone (Agamree)

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 does not expire.

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:

2 1. Is the patient greater than or equal to 2 years of age?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Is the requested medication prescribed by a neurologist?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Does the patient have a diagnosis of Duchenne Muscular Dystrophy (DMD) that has been confirmed by genetic testing or muscle biopsy?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
4. Does the patient have a contraindication to, intolerability to, or has failed a trial of at least 3 months of at least ONE of the following: (1) prednisone; or (2) deflazacort (Emflaza)?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
5. Does the provider acknowledge the FDA safety alerts, warnings, precautions, drug interactions, and monitoring recommendations for the requested medication?	<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:

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_____ Prescriber Signature

_____ Date