US Family Health Plan
Prior Authorization Request Form for trifarotene 0.005% cream **(Aklief)**

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**

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. **This agent has been identified as having cost-effective alternatives including adapalene (cream, gel, and lotion), clindamycin (cream, gel, lotion, and solution), clindamycin/benzoyl peroxide (combination) gel, and tretinoin (cream, and gel). These agents are available without a PA. Please consider changing the prescription to one of these agents.**	Proceed to question **2**
2. **What is the indication or diagnosis?**	☐ Acne Vulgaris – Proceed to question **3** ☐ Other – **STOP Coverage not approved**
3. **Please explain why this agent is required and the patient cannot take the formulary alternatives.** **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

[13 May 2020]