US Family Health Plan
Prior Authorization Request Form for
delgocitinib (Anzupgo)

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 therapy approves for 12 months; annual renewal is required. For renewal of therapy an initial USFHP prior authorization approval is required. Renewal PA criteria will be approved indefinitely. Supporting clinical documentation 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 TRICARE benefit in the last 6 months? ***Please choose*** *"No" if the patient did not previously have a TRICARE approved PA for the requested medication.*	☐ Yes (subject to verification) Proceed to question **9**	☐ No Proceed to question **2**
2. Is the patient 18 years of age or older?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. What is the indication or diagnosis?	☐ Moderate to severe chronic hand eczema- Proceed to question **4** ☐ Other diagnosis - **STOP - Coverage not approved**	
4. Is the requested medication being prescribed by a dermatologist, allergist, or immunologist?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have a contraindication to ONE medication in EACH of the following categories: (a) High potency/class 1 topical corticosteroids (for example, clobetasol propionate 0.05% ointment/cream, fluocinonide 0.05% ointment/cream), (b) Topical calcineurin inhibitor (for example, pimecrolimus, tacrolimus)?	☐ Yes Proceed to question **8**	☐ No Proceed to question **6**

6. Does the patient have an intolerability to ONE medication in EACH of the following categories: (a) High potency/class 1 topical corticosteroids (for example, clobetasol propionate 0.05% ointment/cream, fluocinonide 0.05% ointment/cream), (b) Topical calcineurin inhibitor (for example, pimecrolimus, tacrolimus)?	☐ Yes Proceed to question **8**	☐ No Proceed to question **7**
7. Has the patient failed treatment with ONE medication in EACH of the following categories: (a) High potency/class 1 topical corticosteroids (for example, clobetasol propionate 0.05% ointment/cream, fluocinonide 0.05% ointment/cream), (b) Topical calcineurin inhibitor (for example, pimecrolimus, tacrolimus)?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Is the patient currently using other immuno-biologics (for example, Humira, Stelara etc.), other JAK inhibitors (for example, Xeljanz, Olumiant, Rinvoq), or potent immunosuppressants such as azathioprine or cyclosporine?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
9. Has the patient's disease severity improved and stabilized to warrant continued therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

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

Prescriber Signature _____ Date _____

[04 August 2025]

https://www.usfamilyhealth.org/for-providers/pharmacy-information/