USFHP Prior Authorization Request Form for
gepotidacin (Blujepa)

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

PA renewal is not allowed; no refills allowed; each course of therapy requires a new PA.Clinical documentation may be 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. Is the patient 12 years of age or older?	☐ Yes Proceed to question **2**	☐ No **Stop** **Coverage not approved**
2. Does the patient weigh 40 kilograms OR MORE?	☐ Yes Proceed to question **3**	☐ No **Stop** **Coverage not approved**
3. Does the patient have an uncomplicated urinary tract infection (uUTI) (such as, afebrile, infection that is limited to the bladder, and non-catheter associated infection)?	☐ Yes Proceed to question **4**	☐ No **Stop** **Coverage not approved**
4. **Does the patient have a urine culture indicating the organism is Escherichia coli, Klebsiella pneumoniae, Citrobacter freundii complex, Staphylococcus saprophyticus, or Enterococcus faecalis?**	☐ Yes Proceed to question **5**	☐ No **Stop** **Coverage not approved**
5. Does the patient have a contraindication to or a culture proven resistance to ALL alternative oral antibiotic treatment options (such as, nitrofurantoin, sulfamethoxazole/trimethoprim, fosfomycin, fluoroquinolones, penicillins, and cephalosporins)?	☐ 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 _____

[11 March 2026]