

US Family Health Plan Prior Authorization Request Form for Xanomeline-trospium (Cobenfy)

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):

Patient Name: _____ Address: _____ Sponsor ID #: _____ Date of Birth: _____	Physician Name: _____ Address: _____ Phone #: _____ Secure Fax #: _____
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Step 2 Please complete the clinical assessment:

1. Is the patient 18 years of age or older?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Is the requested drug being prescribed by psychiatrist?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Does the patient have an established, primary diagnosis of schizophrenia?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
4. Does the patient have a history of acute exacerbations OR relapses of psychotic symptoms which have failed to respond to ONE SECOND generation antipsychotic at maximally tolerated doses?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
5. Does the patient have a history of acute exacerbations OR relapses of psychotic symptoms which have failed to respond to ONE FIRST generation antipsychotic at maximally tolerated doses?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No STOP Coverage not approved

6. Is the patient currently being treated for an acute exacerbation or relapse of psychotic symptoms?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
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Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature

Date

[12 Feb 2025]