

US Family Health Plan  
 Prior Authorization Request Form for  
 flurandrenolide 4 mcg/sq.cm (**Cordran**) tape

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 expires after 30 days.

**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 requested medication being prescribed by a dermatologist or plastic surgeon?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
2. Provider acknowledges that this agent has been identified as having cost-effective alternatives, including clobetasol propionate 0.05% ointment and fluocinonide 0.05% cream and fluocinonide 0.05% solution. These agents do not require a PA.	Proceed to question 3	
3. Provider acknowledges that barrier function can be accomplished by using an alternative agent (for example, fluocinonide 0.05% cream) with an occlusive dressing. Please note occlusion increases transmission (i.e., potency); a lower potency agent should be used as an alternative to flurandrenolide tape if used with a barrier.	Proceed to question 4	
4. Has the patient tried for at least 2 weeks and failed, have a contraindication to, or has had an adverse reaction to clobetasol propionate 0.05% ointment OR halobetasol propionate 0.05% ointment OR betamethasone dipropionate 0.05% ointment?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No <b>STOP</b> Coverage not approved

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5. Please describe why Cordran tape is required as opposed to available alternatives.

Sign and date below

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

**3**

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

[4 March 2020]