US Family Health Plan
Prior Authorization Request Form for
diflorasone diacetate 0.05% cream

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**

Medical documentation may be required. Failure to provide could result in denial. 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:**

Question		
1. **This agent has been identified as having cost-effective alternatives including fluocinonide 0.05% and betamethasone/propylene glycol 0.05% creams. These agents do not require a PA.**	Proceed to question **2**	
2. **Has the patient tried for at least 2 weeks and failed, have a contraindication to, or has had an adverse reaction to fluocinonide 0.05%, betamethasone/propylene glycol (augmented) 0.05% AND desoximetasone 0.25% creams?**	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. **Please describe why this agent is required as opposed to available 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

[4 March 2020]