US Family Health Plan
Prior Authorization Request Form for
calcipotriene 0.005% betamethasone 0.064% ointment **(Taclonex, generic)**
calcipotriene 0.005% betamethasone 0.064% cream **(Wynzora)**
calcipotriene0.005% betamethasone 0.064% foam **(Enstilar)**

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**

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. This agent has been identified as having cost-effective alternatives including the following: • **for the calcipotriene (vitamin D analog) component, alternatives include generic calcipotriene 0.005% cream, ointment, and solution;** • **for the betamethasone (high-potency topical corticosteroid) component, alternatives include clobetasol propionate 0.05% ointment, cream, solution, and shampoo and fluocinonide 0.05% cream, ointment, and solution.** **These agents are available without a PA. Please consider changing the prescription to one of these agents.**	☐ Acknowledged Proceed to question **2**	
2. Is the patient 12 years of age or older?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. For which diagnosis is the requested medication being prescribed?	☐ Plaque psoriasis – Proceed to question **4** ☐ Other – **STOP Coverage not approved**	
4. Has the patient experienced an adverse reaction or failure from at least a 2 week trial of at least one high-potency topical corticosteroid (for example, clobetasol 0.05% ointment, cream, solution, shampoo; fluocinonide 0.05% cream, ointment, solution)?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**

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5. Has the patient tried and failed or had an adverse reaction to calcipotriene 0.005% ointment, cream, OR solution?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Has the patient tried and failed an individual calcipotriene agent (calcipotriene 0.005% ointment, cream or solution) AND an individual high-potency topical corticosteroid agent used concurrently?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Please explain why this agent is required and the patient cannot take the 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

[24 February 2021]