US Family Health Plan

Prior Authorization Request Form for

Rosuvastatin Sprinkle Capsules (Ezallor Sprinkle)

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**

Clinical documentation may be required for approval
For patients UNDER 12 years of age, no prior authorization is 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:

Please explain why the patient requires rosuvastatin sprinkle capsules (Ezallor Sprinkle) and cannot take simvastatin, atorvastatin, OR rosuvastatin tablets.

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[13 November 2019]