

US Family Health Plan
Prior Authorization Request Form for
Fenofibrate (**Fenoglide**) 120mg tablet

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. Other formulations of fenofibrate are available without prior authorization, including generic formulations of Tricor, Trilipix, and Lofibra.
2. Please explain why the patient cannot take one generic fenofibrate 134 mg capsule or two fenofibrate 54 mg tablets or another formulation of fenofibrate.

Acknowledged
Proceed to Question 2

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