US Family Health Plan
Prior Authorization Request Form for
Birch triterpenes (Filsuvez)

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**

Initial therapy approves for 6 months, renewal approves for 12 months. For renewal of therapy an initial prior authorization approval 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:**

1. Is the requested medication prescribed by a dermatologist or wound care specialist?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication.*	☐ Yes (subject to verification) Proceed to question **7**	☐ No **Proceed to question 3**
3. Is the patient 6 months of age or older?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. What is the indication or diagnosis?	☐ Dystrophic epidermolysis bullosa (DEB) - Proceed to question **5** ☐ Junctional epidermolysis bullosa (JEB) - Proceed to question **5** ☐ Other – **STOP Coverage not approved**	
5. Does the patient have one or more open wounds that will be treated?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Is the patient's wound clean in appearance and does not appear to be infected?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

7. Has the patient had disease stabilization or improvement in disease on therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

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

Prescriber Signature _____ Date _____

[14 Aug 2024]