US Family Health Plan

Prior Authorization Request Form for

Ivermectin (Stromectol)

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**

Prior authorization expires in 6 months. Note: PA would only apply to outpatient use, and would not impact any investigational protocols.

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 ivermectin being used for an FDA-approved indication including intestinal strongyloidiasis or onchocerciasis (river blindness)?	☐ Yes **Sign and date below**	☐ No Proceed to Question **2**
2. Is ivermectin being used to treat or prevent COVID-19?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to Question **3**
3. Is the requested medication prescribed for ascariasis (roundworm), demodicosis, gnathostomiasis, cutaneous larva migrans (dog and cat hookworm), pediculosis (lice), Mansonella ozzardi infection, Mansonella streptocerca infection, scabies, trichuriasis (whipworm), or Wucheria bancrofti infection?	☐ Yes **Sign and date below**	☐ No Proceed to Question **4**
4. Is ivermectin prescribed by or in consultation with an infectious disease provider?	☐ 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 _____

[20 September 2021]