US Family Health Plan
Prior Authorization Request Form for
Daprodustat (Jesduvroq)

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 approval expires after 6 months, renewal approves for lifetime. For renewal of therapy an initial USFHP prior authorization approval is required. After six months, PA must be resubmitted.

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. 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 Jesduvroq.*	☐ Yes (subject to verification) Proceed to question **9**	☐ No Proceed to question **2**
2. The provider acknowledges that epoetin alfa-epbx (Retacrit) is the preferred erythropoietin stimulating agent (ESA) for TRICARE and is available without prior authorization.	☐ Acknowledged Proceed to question **3**	
3. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the requested medication prescribed by or in consultation with a nephrologist?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. What is the indication or diagnosis?	☐ Anemia due to chronic kidney disease - Proceed to question **6** ☐ No – **STOP** **Coverage not approved**	
6. Has the patient experienced an inadequate response or adverse reaction to Retacrit?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

7. Has the patient been receiving dialysis for at least 4 months?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Is the provider aware of the warnings, screening, and monitoring precautions for the requested medication?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
9. Has the patient had a positive response to therapy as shown by an increase or stabilization in hemoglobin levels or a reduction or absence in red blood cell transfusions?	☐ 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 _____