US Family Health Plan
Prior Authorization Request Form for
Tirbanibulin 1% Ointment (Klisyri)

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**
https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Clinical documentation may be required for approval.

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 patient 18 years of age or older?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication being prescribed by or in consultation with a dermatologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. For which indication is the requested medication being prescribed?	☐ Actinic keratosis of the face or scalp– proceed to question **4** ☐ Other - **STOP Coverage not approved**	
4. Has the patient tried and failed or has a contraindication to fluorouracil and imiquimod?	☐ 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

[02 March 2022]