US Family Health Plan

Prior Authorization Request Form for

Metronidazole oral suspension (**Likmez**)

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 (PA) does not apply to patients 12 years of age and younger.
PA will expire after 6 months. New PA 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. Provider acknowledges that metronidazole tablets are available without prior authorization.	☐ Acknowledged Proceed to question **2**	
2. Does the patient require metronidazole and cannot use the tablet formulation due to some documented medical condition – dysphagia, systemic sclerosis, etc. and not due to convenience?	☐ 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 _____

[6 March 2024]