US Family Health Plan
Prior Authorization Request Form for
Topical Acne and Rosacea Agents: Topical Metronidazole Products

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 after 1 year**.**

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. Does the patient have a diagnosis of rosacea?	☐ Yes Proceed to question 2	☐ No **STOP** **Coverage not approved**
2. Has the patient tried and failed one generic preferred topical metronidazole product (1% gel, 0.75% lotion, or 0.75% cream)?	☐ 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

[8 February 2017]