# US Family Health Plan
# Prior Authorization Request Form for
# semaglutide (**Ozempic**), tirzepatide (**Mounjaro**)

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**

Medical documentation may be required. Failure to provide could result in denial.

**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. Trulicity is the Department of Defense's preferred agent. Trulicity has an indication to reduce the risk of major cardiovascular events in adults with type 2 diabetes mellitus (T2DM) who have estabilished cardiovascular disease or multiple cardiovascular risk factors; Mounjaro does not have this indication. Has the patient tried Trulicity?** | ☐ Yes<br>Proceed to question **2** | ☐ **No**<br>**STOP**<br>**Coverage not approved** |
| **2. Has the patient had an inadequate response to Trulicity?**<br>***Clinical documentation is required*** | ☐ Yes<br>Proceed to question **5** | ☐ **No**<br>Proceed to question 3 |
| **3. Has the patient experienced an adverse reaction to Trulicity that is not expected to occur with the requested agent or is intolerable to that adverse reaction?** | ☐ Yes<br>Proceed to question **4** | ☐ **No**<br>**STOP**<br>**Coverage not approved** |
| **4. Does the patient have a contraindication to Trulicity?** | ☐ Yes<br>Proceed to question **5** | ☐ **No**<br>**STOP**<br>**Coverage not approved** |
| **5. Does the patient have a diagnosis of type 2 diabetes mellitus?** | ☐ **Yes**<br>Proceed to question **6** | ☐ No<br>**STOP**<br>**Coverage not approved** |

| | | |
|---|---|---|
| **6. Has the patient tried metformin (alone or in combination) and failed to achieve blood sugar control?** | ☐ **Yes**<br>**Sign and date below** | ☐ **Yes**<br>Proceed to question **7** |
| **7. Has the patient experienced any of the following adverse events while receiving metformin: impaired renal function that precludes treatment with metformin or a history of lactic acidosis?** | ☐ **Yes**<br>**Sign and date below** | ☐ **Yes**<br>Proceed to question **8** |
| **8. Does the patient have a contraindication to metformin?** | ☐ **Yes**<br>**Sign and date below** | ☐ No<br>**STOP**<br>**Coverage not approved** |

**Step 3**

**I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____