USFHP Prior Authorization Request Form for

Micronized Progesterone Capsule, Medroxyprogesterone Tablets, Progesterone Vials

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/

Prior authorization does not expire. Clinical documentation may be 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. What is the patient's sex?	☐ Male – Proceed to question **2** ☐ Female – **Prior authorization is not required**
2. How old is the patient?	☐ 18 years of age or younger – Proceed to question **3** ☐ 19 years of age or older – Proceed to question **4**
3. What is the indication or diagnosis?	☐ Treatment of male to female hormone therapy in a natal male patient – **STOP - Coverage not approved** ☐ Other diagnosis - **Sign and date below**
4. What is the indication or diagnosis?	☐ Initiation of male to female hormone therapy in a natal male patient – Proceed to question **5** ☐ Continuation of male to female hormone therapy in a natal male patient – **Sign and date below** ☐ Other diagnosis - **Sign and date below**
5. Is the patient a male active duty servicemember?	☐ Yes (Male active duty servicemembers) – **STOP - Coverage not approved** ☐ No (Male non-active duty servicemembers) - **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[26 May 2025]