US Family Health Plan
Prior Authorization Request Form for
glycopyrronium 2.4% topical cloth **(Qbrexza)**

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**

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 9 years of age or older?	☐ Yes Proceed to question 2	☐ No **STOP** **Coverage not approved**
2. Has the patient had a diagnosis of primary axillary hyperhidrosis for greater than or equal to 6 months?	☐ Yes Proceed to question 3	☐ No **STOP** **Coverage not approved**
3. Is the requested medication being prescribed by or in consultation with a dermatologist?	☐ Yes Proceed to question 4	☐ No **STOP** **Coverage not approved**
4. Has the patient tried and failed at least one topical 20% or higher aluminum salt (either OTC or prescription)?	☐ Yes Proceed to question 5	☐ No **STOP** **Coverage not approved**
5. Has the patient tried and failed at least one additional option (for example, Botox, MiraDry, iontophoresis, oral anticholinergics [glycopyrrolate, oxybutynin, propantheline], propranolol, clonidine, or diltiazem)?	☐ 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 2019]