

US Family Health Plan  
 Prior Authorization Request Form for  
 prednisone delayed released (**Rayos**)

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: _____ Address: _____ Sponsor ID #: _____ Date of Birth: _____	Physician Name: _____ Address: _____ Phone #: _____ Secure Fax #: _____
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**Step 2** Please complete the clinical assessment:

<b>1. Prednisone (immediate-release) is the DoD's preferred product and is covered without prior authorization.</b>  <b>Does the prescriber acknowledge this preference?</b>	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>2. Please explain the clinical rationale of why the patient requires delayed release prednisone <u>and</u> why patient cannot take immediate release prednisone.</b>		
<b>3. Are there any other comments, diagnoses, symptoms, medications tried and/or any other information important to this review?</b>		
<b>Sign and date below</b>		

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

**3**

\_\_\_\_\_ Prescriber Signature

\_\_\_\_\_ Date