

US Family Health Plan

Prior Authorization Request Form for Semaglutide Oral Tablet (Rybelsus)

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/>

Step 1 Please complete patient and physician information (please print):

1

Patient Name: _____

Physician Name: _____

Address: _____

Address: _____

Sponsor ID #: _____

Phone #: _____

Date of Birth: _____

Secure Fax #: _____

Step 2 Please complete the clinical assessment:

2

1. Is the patient GREATER THAN or EQUAL to 18 years of age?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No Stop Coverage not approved
2. Does the patient have a documented diagnosis of type 2 diabetes mellitus ¹ ?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No Stop Coverage not approved
3. Has the patient tried and had an inadequate response to metformin, or has a contraindication to metformin?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No Stop Coverage not approved
4. Has the patient tried and had an inadequate response to Trulicity, or has a contraindication to Trulicity? **Clinical documentation required**	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No Stop Coverage not approved
5. Is the patient able to adhere to the administration requirements (take on an empty stomach with no more than 4 oz. of water at least 30 min before the first meal of the day)?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No Stop Coverage not approved
6. Is the patient a female AND pregnant?	<input type="checkbox"/> Yes Stop Coverage not approved	<input type="checkbox"/> No Proceed to question 7
7. Does the patient have a history of pancreatitis?	<input type="checkbox"/> Yes Stop Coverage not approved	<input type="checkbox"/> No Proceed to question 8

Prior Authorization Request Form for
Semaglutide oral tablet (Rybelsus)

8. Does the patient have a personal or family history of medullary thyroid carcinoma (MTC)?	<input type="checkbox"/> Yes Stop Coverage not approved	<input type="checkbox"/> No Proceed to question 9
9. Does the patient have multiple endocrine neoplasia syndrome type 2 (MEN2)?	<input type="checkbox"/> Yes Stop Coverage not approved	<input type="checkbox"/> No Proceed to question 10
10. Patient and provider acknowledge that Rybelsus has not been shown to reduce the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with type 2 diabetes mellitus and established cardiovascular disease?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Stop Coverage not approved

¹ Non-FDA approved uses are not approved including weight loss (obesity) or type 1 diabetes mellitus

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

Prescriber Signature

Date

25 August 2023