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**

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:**

Question		
1. Is the patient GREATER THAN or EQUAL to 18 years of age?	☐ Yes Proceed to question **2**	☐ No **Stop** **Coverage not approved**
2. Does the patient have a documented diagnosis of type 2 diabetes mellitus [1] ?	☐ Yes Proceed to question **3**	☐ No **Stop** **Coverage not approved**
3. Has the patient tried and had an inadequate response to metformin, or has a contraindication to metformin?	☐ Yes Proceed to question **4**	☐ No **Stop** **Coverage not approved**
4. Has the patient tried and had an inadequate response to Trulicty, or has a contraindication to Trulicty? ****Clinical documentation required****	☐ Yes Proceed to question **5**	☐ 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)?	☐ Yes Proceed to question **6**	☐ No **Stop** **Coverage not approved**
6. Is the patient a female AND pregnant?	☐ Yes **Stop** **Coverage not approved**	☐ No Proceed to question **7**
7. Does the patient have a history of pancreatitis?	☐ Yes **Stop** **Coverage not approved**	☐ No Proceed to question **8**

8. Does the patient have a personal or family history of medullary thyroid carcinoma (MTC)?	☐ Yes **Stop** **Coverage not approved**	☐ No Proceed to question **9**
9. Does the patient have multiple endocrine neoplasia syndrome type 2 (MEN2)?	☐ Yes **Stop** **Coverage not approved**	☐ 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?	☐ Yes **Sign and date below**	☐ 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

[19 February 2020]