US Family Health Plan
Prior Authorization Request Form for
Sofpironium Bromide (Sofdra)

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**

Prior authorization does not expire.

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. Is the requested medication prescribed by a dermatologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. What is the indication or diagnosis? **Note: This medication is NOT for the treatment of palmar, plantar, facial, or other forms of hyperhidrosis.**	☐ Primary axillary hyperhidrosis for greater than or equal to 6 months - Proceed to question **4** ☐ Other diagnosis – **STOP Coverage not approved**	
4. Has the patient tried and failed AT LEAST ONE topical 20% or higher aluminum salt antiperspirant (either OTC or prescription; for example, Drysol)?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Has the patient tried and failed AT LEAST TWO additional options (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 _____

[12 February 2025]