US Family Health Plan
Prior Authorization Request Form for
sulfacetamide and sulfacetamide sodium/sulfur

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. This agent has been identified as having cost-effective alternatives including sulfacetamide 10% lotion/suspension (Klaron, generics) and sulfacetamide/sulfur 10%-5% cleanser (Rosanil, Avar, generics). Generic Klaron lotion/suspension and generic Rosanil or Avar cleanser are available without requiring prior authorization. Please consider changing the prescription to these preferred sulfacetamide formulations.	☐ Acknowledged Proceed to question **2**
2. Please explain why this agent is required and the patient cannot take the preferred sulfacetamide formulations.	_____ **Sign and date below**

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

_____ _____
Prescriber Signature Date

[29 July 2020]