US Family Health Plan
Authorization Request Form for
tazarotene 0.05% gel (Tazorac), tazarotene 0.1% gel (Tazorac), tazarotene 0.05% cream (Tazorac)

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 a cost-effective alternative tazarotene 0.1% cream. Tazarotene 0.1% cream is available without a PA. Please consider changing the prescription this agent.	☐ Acknowledged Proceed to question **2**	
2. For which diagnosis is the requested medication being prescribed?	☐ Acne Vulgaris – Proceed to question **3** ☐ Plaque psoriasis – Proceed to question **5** ☐ Other – **STOP Coverage not approved**	
3. Is the patient 12 years of age or older?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Has the patient tried and experienced failure, an adverse reaction or have a contraindication to tazarotene 0.1% cream?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
5. Is the patient 18 years of age or older?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Where is the plaque psoriasis located?	☐ Scalp - Proceed to question **7** ☐ All other body areas - Proceed to question **8**	

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7. Has the patient experienced an adverse reaction or failure from at least a 2 week trial of at least one high-potency topical corticosteroid (for example, clobetasol 0.05% solution, shampoo; or fluocinonide 0.05% solution)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
8. Has the patient experienced an adverse reaction or failure from at least a 2 week trial of at least one high-potency topical corticosteroid (for example, clobetasol 0.05% ointment, cream, solution, shampoo; fluocinonide 0.05% cream, ointment, solution)?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Has the patient tried and failed or had an adverse reaction to tazarotene 0.1% cream?	☐ 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

[24 February 2021]