US Family Health Plan
Prior Authorization Request Form for
levothyroxine sodium solution **(Ermeza, Thyquidity, Tirosint-SOL**)

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**

For patients UNDER 6 years of age, no prior authorization is required. Prior authorization expires after 1 year.

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	Yes	No
1. Is the patient less than 6 years of age?	☐ Yes **STOP** **Prior Authorization Not Required**	☐ No Proceed to question **2**
2. Is the patient able to chew a levothyroxine tablet?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **3**
3. Is the patient able to swallow a capsule or tablet?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **4**
4. Is the requested medication being prescribed by or in consultation with an endocrinologist?	☐ 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

[10 January 2023]