US Family Health Plan
Prior Authorization Request Form for
Topical Acne and Rosacea Agents: Miscellaneous Topical Agents

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 expires after one 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:**

1. Is the patient 18 years of age or older?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. What medication is being requested?	☐ Rhofade - Proceed to question **3** ☐ Mirvaso - Proceed to question **4** ☐ Soolantra - Proceed to question **5** ☐ Zilxi - Proceed to question **5**	
3. Does the patient have persistent facial erythema associated with rosacea?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
4. Does the patient have non-transient, persistent facial erythema of rosacea?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
5. Does the patient have inflammatory lesions of rosacea?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Has the patient tried and failed one generic preferred formulary topical metronidazole product (1% gel, 0.75% lotion, or 0.75% cream)?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Has the patient tried and failed topical azelaic acid?	☐ 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 _____