US Family Health Plan

Prior Authorization Request Form for

Alogliptin (Nesina), Alogliptin / Pioglitazone (Oseni)

Linagliptin (Tradjenta), Saxagliptin (Onglyza)

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**

Medication requested:

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. Has the patient tried at least ONE of the following and failed to achieve glycemic control: METFORMIN (alone or in combination) **or a SULFONYLUREA** (alone or in combination)**?**	☐ Yes **SKIP** to question **5**	☐ No Proceed to question **2**
2. Has the patient experienced any of the following adverse events while receiving metformin: impaired renal function that precludes treatment with metformin or a history of lactic acidosis?	☐ Yes **SKIP** to question **5**	☐ No Proceed to question **3**
3. Has the patient experienced the following adverse event while receiving a sulfonylurea: hypoglycemia requiring medical treatment?	☐ Yes **SKIP** to question **5**	☐ No Proceed to question **4**
4. Does the patient have a contraindication to BOTH metformin and a sulfonylurea?	☐ Yes Proceed to question **5**	☐ No **STOP Coverage not approved**
5. Has the patient experienced an adverse event with a sitagliptin-containing product (i.e., a product that contains Januvia) **which is not expected to occur with an alogliptin-, saxagliptin- or linagliptin-containing product** (i.e., a product containing Nesina, Onglyza, Oseni or Tradjenta)**?**	☐ Yes **Sign and date below**	☐ No Proceed to question **6**
6. Has the patient had an inadequate response to a sitagliptin-containing product (i.e., a product that contains Januvia)**?**	☐ Yes **Sign and date below**	☐ No Proceed to question **7**

	7. Does the patient have a contraindication to sitagliptin (i.e., Januvia) **which is not expected to exist with an alogliptin-, saxagliptin- or linagliptin-containing product?**	☐ Yes **Sign and date below**	☐ No **Coverage not approved**
Step 3	**I certify the above is true to the best of my knowledge.** Please sign and date:		

Prescriber Signature _____ Date _____

[3 July 2013]