US Family Health Plan
Prior Authorization Request Form for
Dulaglutide (Trulicity)

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**

Clinical documentation may be required.

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. Does the patient have a diagnosis of type 2 diabetes mellitus?	☐ Yes Proceed to question 2	☐ No **STOP** **Coverage not approved**
2. Has the patient tried metformin (alone or in combination) and failed to achieve blood sugar control?	☐ Yes **Sign and date below**	☐ No Proceed to question 3
3. Has the patient experienced any of the following adverse events that precludes treatment with metformin: impaired renal function or a history of lactic acidosis?	☐ Yes **Sign and date below**	☐ No Proceed to question 4
4. Does the patient have a contraindication to metformin?	☐ 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 _____

[28 September 2022]