US Family Health Plan
Prior Authorization Request Form

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** **usfamilyhealth.org/rx-pa**

This form is being used for:		
Check one:	☐ Initial Request	☐ Continuation/Renewal Request
Reason for request *(check all that apply)*:	Prior Authorization, Step Therapy, Formulary Exception Quantity Exception Specialty Drug Other *(please specify)*: ________	
Check if Expedited Review/Urgent Request:	☐ (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request.)	

Patient Information		
Patient Name:	DOB:	Gender: ☐ Male ☐ Female ☐ Unknown
Member ID #:		

Prescriber Information	
Prescribing Clinician:	Phone #:
Specialty:	Secure Fax #:
NPI #:	DEA/xDEA:
Prescriber Point of Contact Name (POC) (if different than provider):	
POC Phone #:	POC Secure Fax #:
POC Email (not required):	
Prescribing Clinician or Authorized Representative Signature:	
Date:	

Medication Information	
Medication Being Requested:	
Strength:	Quantity:
Dosing Schedule:	Length of Therapy:
Date Therapy Initiated:	
Is the patient currently being treated with the drug requested? ☐ Yes ☐ No	If yes, date started:
Dispense as Written (DAW) Specified? ☐ Yes ☐ No	
Rationale for DAW:	

Compound and Off Label Use	
Is Medication a Compound? ☐ Yes ☐ No	
If Medication Is a Compound, List Ingredients:	
For Compound or Off Label Use, include citation to peer reviewed literature:	

(continued on next page)

Patient Clinical Information
***Please refer to plan-specific criteria for details related to required information.**
Primary Diagnosis Related to Medication Request:
ICD Codes:
Pertinent Comorbidities:
If Relevant to This Request:
Drug Allergies:
Height: Weight:
Pertinent Concurrent Medications:
Opioid Management Tools in Place: ☐ Risk assessment ☐ Treatment Plan ☐ Informed Consent ☐ Pain Contract ☐ Pharmacy/Prescriber Restriction
Previous Therapies Tried/Failed:

Previous Therapies

Drug Name	Strength	Dosing Schedule	Date Prescribed	Date Stopped	Description of Adverse Reaction or Failure	Check if Sample
						☐
						☐
						☐
						☐
						☐

Are there contraindications to alternative therapies? ☐ Yes ☐ No

If yes, please list details:

Were nonpharmacologic therapies tried? ☐ Yes ☐ No

If yes, provide details:

Relevant Lab Values

Lab Name and Lab Value	Date Performed	Lab Name and Lab Value	Date Performed

If renewal, has the patient shown improvement in related condition while on therapy? ☐ Yes ☐ No ☐ N/A

If yes, please describe:

Additional information pertinent to this request:

Complete this section for Professionally Administered Medications *(including Buy and Bill).*

Start Date: ______ End Date: ______

Servicing Prescriber/Facility Name: ______ ☐ Same as Prescribing Clinician

Servicing Provider/Facility Address: ______

Servicing Provider NPI/Tax ID #: ______

Name of Billing Provider: ______

Billing Provider NPI #: ______

Is this a request for reauthorization? ☐ Yes ☐ No

CPT Code: ______ # of Visits ______ J Code: ______ # of Units: ______

Providers may attach any additional data relevant to medical necessity criteria.