USFHP Prior Authorization Request Form for clascoterone **(Winlevi)**

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

https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Prior authorization does not expire. 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. Adapalene (cream, gel, lotion), clindamycin (cream, gel, lotion, solution), clindamycin/benzoyl peroxide (combination) gel, tretinoin (cream, gel), and spironolactone (tablets) are available to DoD beneficiaries without requiring prior authorization. Please consider changing the prescription to a formulary preferred medication.	☐ Acknowledged Proceed to question **2**	
2. Does the patient have a diagnosis of acne vulgaris? **Note: Non-FDA-approved uses are not approved, including for hair loss**	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. Is the patient greater than or equal to 12 years of age?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Is the requested medication prescribed by or in consultation with a dermatologist?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. Does provider acknowledge a potential increased risk of hypothalamic-pituitary-adrenal axis suppression in adolescents compared to adults?	☐ Yes Proceed to question **6**	☐ No **STOP** Coverage not approved
6. Has the patient tried and failed or has contraindications to a topical retinoid product and to a combination of topical clindamycin and benzoyl peroxide product?	☐ Yes Proceed to question **7**	☐ No **STOP** Coverage not approved

7. Has the patient tried and failed or has contraindications to at least one oral medication (spironolactone, a combined oral contraceptive, OR isotretinoin) for acne?	☐ Yes Proceed to question **8**	☐ No **STOP** Coverage not approved

8. Please provide the date of when the patient previously tried each medication or the contraindication for each medication listed below.

Note: The dates for each medication or contraindication to each medication listed below must be provided or your case could be denied.

Category	Drug	Drug response	
		Date of trial and failure	**Contraindication to medication**
Topical retinoid			
Combination topical clindamycin with benzoyl peroxide			
Oral medication (spironolactone, a combined oral contraceptive, OR isotretinoin)			

Sign and date below

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date.

Prescriber Signature _____ Date _____