

US Family Health Plan

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**

NOTE: Medical documentation may be requested or your request could be denied.

Step 1 Please complete patient and physician information (please print):

Patient Name: _____ Address: _____ Sponsor ID #: _____ Date of Birth: _____	Physician Name: _____ Address: _____ Phone #: _____ Secure Fax #: _____
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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.	<input type="checkbox"/> 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	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Is the patient 12 years of age or older?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
4. Is the requested medication prescribed by or in consultation with a dermatologist?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
5. Does provider acknowledge a potential increased risk of hypothalamic-pituitary-adrenal axis suppression in adolescents compared to adults?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved
7. Has the patient tried and failed or has contraindications to at least one oral medication (such as, spironolactone, a combined oral contraceptive, OR isotretinoin) for acne?	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> No STOP Coverage not approved



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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 (such as, 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