US Family Health Plan
Prior Authorization Request Form for
Tenapanor (Xphozah)

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**

· Prior authorization does not expire.

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. Is the patient 18 years of age or older?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication prescribed by or in consultation with a nephrologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. What is the indication or diagnosis? Note: Non-FDA approved uses are NOT approved, including constipation-predominant irritable bowel syndrome (IBS-C).	☐ Hyperphosphatemia in chronic kidney disease (CKD) - Proceed to question **4** ☐ Other – **STOP Coverage not approved**	
4. Has the patient been receiving maintenance dialysis for at least 3 months?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is the patient's serum phosphate level greater than 5.5. mg/dL and less than 10 mg/dL?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Has the patient tried and had an inadequate response to at least two phosphate binders (for example, sevelamer (Renagel, Renvela), lanthanum (Fosrenol), ferric citrate (Auryxia), sucroferric oxyhydroxide (Velphoro), calcium carbonate, calcium acetate)?	☐ Yes **Sign and date below**	☐ No Proceed to question **7**

7. Has the patient tried and been unable to tolerate at least two phosphate binders (for example, sevelamer (Renagel, Renvela), lanthanum (Fosrenol), ferric citrate (Auryxia), sucroferric oxyhydroxide (Velphoro), calcium carbonate, calcium acetate)?	☐ Yes **Sign and date below**	☐ No Proceed to question **8**
8. Does the patient have a contraindication to at least two phosphate binders (for example, sevelamer (Renagel, Renvela), lanthanum (Fosrenol), ferric citrate (Auryxia), sucroferric oxyhydroxide (Velphoro), calcium carbonate, calcium acetate). Contraindications to phosphate binders includes bowel obstruction, iron overload, or hypercalcemia?	☐ Yes **Sign and date below**	☐ No Proceed to question **9**
9. Has the patient had intolerance to any dose of phosphate binder therapy?	☐ 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 _____