US Family Health Plan
Prior Authorization Request Form for
Pancrelipase (Zenpep)

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**

Creon is the preferred pancreatic enzyme replacement product; prior authorization is not required for Creon.

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 less than or equal to 2 years of age?	☐ Yes **Proceed to question 2**	☐ No **Proceed to question 3**
2. Has the patient had a sufficient trial of Creon and treatment was unsuccessful?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
3. Has the patient failed an adequate trial of Creon, defined as at least 2 dose adjustments done over a period of at least 4 weeks? ***Please provide the trial dates*** _____	☐ Yes **Proceed to question 4**	☐ No **STOP** **Coverage not approved**
4. Has the patient failed an adequate trial of Pancreaze, defined as at least 2 dose adjustments done over a period of at least 4 weeks? ***Please provide the trial dates*** _____	☐ Yes **Proceed to question 5**	☐ No **STOP** **Coverage not approved**
5. Has the patient failed an adequate trial of Pertzye, defined as at least 2 dose adjustments done over a period of at least 4 weeks? ***Please provide the trial dates*** _____	☐ Yes **Proceed to question 6**	☐ No **STOP** **Coverage not approved**

6. Has the patient failed an adequate trial of Viokace, defined as at least 2 dose adjustments done over a period of at least 4 week? ***Please provide the trial dates*** **_____**	☐ Yes **Sign and date below**	☐ No **Proceed to question 7**
7. Is the patient between 2 and 19 years of age?	☐ Yes **Proceed to question 8**	☐ No **STOP** **Coverage not approved**
8. Does the patient require a dosage strength that is not available with Viokace?	☐ Yes **Sign and date below**	**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

[31 July 2019]