US Family Health Plan
Prior Authorization Request Form for
cetirizine 0.24% ophthalmic solution (**Zerviate**)

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**

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. Does the patient have ocular symptoms of allergic conjunctivitis?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Has the patient tried and failed TWO of the following formulary alternatives in the last 90 days: olopatadine 0.1%, olopatadine 0.7% (Pazeo), azelastine, or epinastine?	☐ Yes **Sign and date below**	☐ No Proceed to question **3**
3. Has the patient experienced intolerable adverse effects to at least TWO of the following formulary alternatives: olopatadine 0.1%, olopatadine 0.7% (Pazeo), azelastine, or epinastine?	☐ 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

[05 August 2020]