US Family Health Plan

Prior Authorization Request Form for

Sitagliptin (Zituvio), sitagliptin-metformin (Zituvimet/Zituvimet XR)

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**

Clinical documentation may be required for approval.

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. Provider acknowledges that Januvia and its combination products are DoD's preferred dipeptidyl peptidase-4 inhibitors and are available to TRICARE beneficiaries without requiring prior authorization. Please type "acknowledged" to proceed.	☐ Acknowledged Proceed to question **2**
2. Please document why the patient cannot use the brand Januvia or Janumet or Janumet XR.	_____ **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

[22 October 2024]