

# US Family Health Plan Prior Authorization Request Form for Januvia, Janumet, Kombiglyze XR, Onglyza, Tradjenta (DPP-4 inhibitors)

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.

<b>MAIL ORDER</b>	<b>If the prescription is to be filled through the USFHP Mail Order Pharmacy, check here <input type="checkbox"/></b>	<b>RETAIL</b>	<b>If the prescription is to be filled at a retail pharmacy, check here <input type="checkbox"/></b>
	<ul style="list-style-type: none"> <li>The completed form and the prescription may be <b>faxed to 1-617-562-5296</b> OR</li> <li>The patient may attach the completed form to the prescription and <b>mail</b> it to: <b>Attn: Pharmacy, 77 Warren Street, Brighton, MA 02135</b></li> </ul>		<ul style="list-style-type: none"> <li>The provider may <b>call: 1-877-880-7007</b></li> <li style="text-align: center; padding: 5px 0;">OR</li> <li>The completed form may be <b>faxed to 1-617-562-5296</b></li> </ul>

Prior authorization criteria and a copy of this form are available at: [http://pec.ha.osd.mil/forms\\_criteria.php](http://pec.ha.osd.mil/forms_criteria.php). This prior authorization has no expiration date.

**Step 1 Please complete patient and physician information (Please Print)**

<b>1</b>	Patient Name: _____	Physician Name: _____
	Address: _____	Address: _____
	Sponsor ID: _____	Phone #: _____
	Date of Birth: _____	Secure Fax: _____

**Step 2 Please complete the clinical assessment:**

**2**

1. Has the patient tried at least ONE of the following and failed to achieve glycemic control: METFORMIN (alone or in combination) or a SULFONYLUREA (alone or in combination)?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 2
2. Has the patient experienced any of the following adverse events while receiving metformin: impaired renal function that precludes treatment with metformin or a history of lactic acidosis?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 3
3. Has the patient experienced the following adverse event while receiving a sulfonylurea: hypoglycemia requiring medical treatment?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 4
4. Does the patient have a contraindication to BOTH metformin and a sulfonylurea?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Coverage not approved

**Step 3 I certify the above is correct and accurate to the best of my knowledge. Please Sign and Date:**

**3**

\_\_\_\_\_

Prescriber Signature

\_\_\_\_\_

Date