

TRICARE Prior Authorization Request Form for  
diflorasone 0.05% ointment, amcinonide 0.1% ointment



JOHNS HOPKINS  
HEALTHCARE

7231 Parkway Drive, Suite 100, Hanover, MD 21076

**FAX Completed Form and  
Applicable Progress Notes to:  
(410) 424-4037**

## USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

**Questions?** Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization expires after 30 days.

**Step** Please complete patient and physician information (please print):

**1**

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID #: _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

**Step** Please complete the clinical assessment:

**2**

1. This agent has been identified as having cost-effective alternatives including clobetasol propionate 0.05% and fluocinonide 0.05% ointments. These agents do not require a PA.	Proceed to question 2	
1. Has the patient tried for at least 2 weeks and failed, have a contraindication to, or has had an adverse reaction to fluocinonide 0.05%, desoximetasone 0.25% AND betamethasone dipropionate 0.05% ointments?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
2. Please describe why this agent is required as opposed to available alternatives.		
Sign and date below		

**Step** I certify the above is true to the best of my knowledge. Please sign and date:

**3**

_____	_____
Prescriber Signature	Date

[4 March 2020]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: