TRICARE Prior Authorization Request Form for Azesco, Zalvit, Trinaz, Neonatal-DHA, Neonatal Fe, Neonatal Complete, Neonatal Plus, Natal PNV



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

Prescriber Signature

USFHP Pharmacy Prior Authorization Form

INS HOPKINS	To be completed by requesting provider			
EALTH PLANS y Drive, Suite 100. Hanover, MD 21076	Drug Name:	1 6	Strength:	
mpleted Form and able Progress Notes to: 4-4037	Dosage/Frequency (SIG): Questions? Contact the Pharmacy		Duration of Therapy: y Dept at: (888) 819-1043, option	
al Documentation mu	·	•	. , ,	
Vitamins, Prenatal Multi plus DHA information that will be used to dete Vitamins Plus Low I, Prenatal Plu	A, Prenatal Vitamin plus Low Iron rmine if the use of the non-preferred	, or Prenatal Plus d prenatal vitamin	s DHA. The purpose of this form is to provide is medically necessary instead of Prenatal	
Iron, or Prenatal Plus DHA. Please complete patient and	physician information (please	e print):		
Patient Name:				
Address:		Address:		
Sponsor ID #:		Phone #:		
Date of Birth:		Secure Fax #:		
Please complete the clinical as	ssessment:			
Preplus, Prenatal, Prenata plus DHA, Prenatal Vitami Prenatal Plus DHA are the are covered without a pric who are under the age of become pregnant or who	Il Vitamins, Prenatal Multi n plus Low Iron, and preferred products and or authorization for women 45 years and planning to are pregnant. Please		☐ Acknowledged proceed to question 2	
effective alternatives inclu Plus Low I, Prenatal Plus, Prenatal Vitamins, Prenata Vitamin plus Low Iron, and	Iding Prenatal Vitamins Preplus, Prenatal, al Multi plus DHA, Prenatal d Prenatal Plus DHA. drug is required and the		Sign and date below	
	mpleted Form and able Progress Notes to: 4-4037 al Documentation must be information that will be used to dete vitamins, Prenatal Multi plus DHA. Please complete patient and Patient Name: Address: Sponsor ID #: Date of Birth: Please complete the clinical as 1. Prenatal Plus DHA are the are covered without a price who are under the age of a become pregnant or who consider changing the preagents. 2. This agent has been idented effective alternatives included and plus Low I, Prenatal Plus, Prenatal Vitamins, Prenatal Vitamin plus Low Iron, and Vitamin plus Iron VIII plus Iron	Drug Name: Drug Name: Drug Name: Drug Name: Drug Name: Dosage/Frequency (SIG): Dosage/Frequency (SIG): Dosage/Frequency (SIG): Questions? Contact to Questions? Contact to Questions? Contact to Al Documentation must accompany form ote: You do NOT need to complete this form for coverage of Prenatal Vitarins, Prenatal Multi plus DHA, Prenatal Vitamin plus Low Iron information that will be used to determine if the use of the non-preferred Vitamins Plus Low I, Prenatal Plus, Preplus, Prenatal, Prenatal Vitarino, or Prenatal Plus DHA. Please complete patient and physician information (please Patient Name: Address: Sponsor ID #: Date of Birth: Please complete the clinical assessment: 1. Prenatal Vitamins Plus Low I, Prenatal Plus, Preplus, Prenatal, Prenatal Vitamins, Prenatal Multi plus DHA, Prenatal Vitamin plus Low Iron, and Prenatal Plus DHA are the preferred products and are covered without a prior authorization for women who are under the age of 45 years and planning to become pregnant or who are pregnant. Please consider changing the prescription to one of these	Drug Name: Drug Name: Drug Name: Drug Name: Drug Name: Dosage/Frequency (SIG): Dosage/Fequency (Sig): Dosage/Frequency Pharmacle Sub, page of the brands Dosage/Frequency Dosage/Frequency Penatal Vitamins Plus Low I, penatal Vitamins Plus Low In nor dosage of the non-prefered preducate of the non-prefered preducate of the non-prefered	

Date

For Internal Use Only			
Approved:	Duration of Approval:month(s)		
Denied:	Authorized By:		
☐ Incomplete/Other:	PA#:		
Date Faxed to MD:	Date Decision Rendered:		