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

JOHNS HOPKINS
HEALTH PLANS
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.

Please note:

- You do NOT need to complete this form for coverage of **Prenatal Vitamins Plus Low I, Prenatal Plus, Preplus, Prenatal, Prenatal Vitamins, Prenatal Multi plus DHA, Prenatal Vitamin plus Low Iron, or Prenatal Plus DHA**. The purpose of this form is to provide information that will be used to determine if the use of the non-preferred prenatal vitamin is medically necessary instead of **Prenatal Vitamins Plus Low I, Prenatal Plus, Preplus, Prenatal, Prenatal Vitamins, Prenatal Multi plus DHA, Prenatal Vitamin plus Low Iron, or Prenatal Plus DHA**.

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. 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 agents.	☐ Acknowledged proceed to question **2**
2. This agent has been identified as having cost-effective alternatives including Prenatal Vitamins Plus Low I, Prenatal Plus, Preplus, Prenatal, Prenatal Vitamins, Prenatal Multi plus DHA, Prenatal Vitamin plus Low Iron, and Prenatal Plus DHA. Please describe why this drug is required and the patient cannot take the available alternatives.	______________________ **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

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