

TRICARE Prior Authorization Request Form for  
Insulin glargine (**Basaglar Tempo**)



**JOHNS HOPKINS**  
MEDICINE

JOHNS HOPKINS  
HEALTHCARE

7231 Parkway Drive, Suite 100, Hanover, MD 21076

## USFHP Pharmacy Prior Authorization Form

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

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

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

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

**Step 1** Please complete patient and physician information (please print):

1 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 Lantus is the DoD's preferred basal insulin and preferred insulin glargine. No prior authorization is required for Lantus. Lantus is available at the lowest Tier 1 copay.	<input type="checkbox"/> Acknowledged Proceed to question 2	
2. Has the patient tried and failed Lantus?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
3. Please document why the patient cannot use the Basaglar Kwikpen version.	<hr/> <p style="text-align: center;">Sign and date below</p>	

**Step 3** I certify the above is true to the best of my knowledge. Please sign and date:

_____	_____
Prescriber Signature	Date

[06 January 2023]

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: