TRICARE Prior Authorization Request Form for Basal Insulin Analogs: Basaglar (Tempo/ Kwikpen), Semglee, Semglee (YFGN), Insulin Glargine-YFGN, Insulin Glargine, Insulin Glargine Solostar, Rezvoglar

JOHNS HOPKINS
HEALTH PLANS

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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.

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. **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.**	☐ **Acknowledged** **Proceed to Question 2**	
2. **Has the patient tried and had an inadequate response to Lantus?**	☐ **Yes** **Sign and date below**	☐ **No** **STOP** **Coverage not approved**

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

_____ _____

Prescriber Signature Date

[30 October 2024]

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