

TRICARE Prior Authorization Request Form for
bupirone (Bucapsol)



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 does not expire.

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. This agent has been identified as having cost-effective alternatives including generic bupirone 5, 10, 15, and 30 mg tablets (scored). These agents are available without prior authorization (PA). Please consider changing the prescription to one of these agents.

☐ Acknowledged
Proceed to question 2

2. Please provide a clinical rationale as to why the patient requires bupirone (Bucapsol) and cannot take the cost-effective generic bupirone formulations.

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

[30 September 2025]

For Internal Use Only

☐ Approved:	Duration of Approval: ____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: