

TRICARE Prior Authorization Request Form for
ibuprofen/acetaminophen (Combogesic) tablets



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 until implementation of complete exclusion status.

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 Combogesic will be completely excluded from the TRICARE pharmacy benefit 120 days after the signing of the P&T Committee meeting minutes by the Director, DHA.	☐ Acknowledged Proceed to question 2	
2. Provider acknowledges that other formulations of acetaminophen and ibuprofen are available to TRICARE beneficiaries and do not require prior authorization.	☐ Acknowledged Proceed to question 3	
3. Is the patient 18 years of age or older?	☐ Yes Proceed to question 4	☐ No STOP Coverage not approved
4. What is the indication or diagnosis?	☐ Short-term mild to moderate acute pain - Proceed to question 5 ☐ Other Diagnosis - STOP - Coverage not approved	

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5. Please document why the patient cannot take
formulary alternatives or OTC products.

Sign and date below

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

Prescriber Signature

Date

[12 August 2026]

For Internal Use Only

☐ Approved:

Duration of Approval: ____month(s)

☐ Denied:

Authorized By:

☐ Incomplete/Other:

PA#:

Date Faxed to MD:

Date Decision Rendered: