TRICARE Prior Authorization Request Form for
trientine tetrahydrochloride (**Cuvrior**)

JOHNS HOPKINS
HEALTH PLANS
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USFHP Pharmacy Prior Authorization Form

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

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 Cuvrior will be completely excluded from the TRICARE pharmacy benefit starting on 2/28/2024, regardless of how long the PA is approved.

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 Cuvrior will be completely excluded from the Tricare Pharmacy Benefit starting on February 28th, 2024, regardless of how long the PA is approved.	☐ Acknowledged Proceed to question **2**	
2. Provider acknowledges that generic trientine hydrochloride capsules are available without prior authorization.	☐ Acknowledged Proceed to question **3**	
3. Has the patient tried and failed generic trientine hydrochloride capsules?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Provider please document why the patient cannot use generic trientine hydrochloride capsules.	_____ **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

[15 Nov 2023]

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