TRICARE Prior Authorization Request Form for

dabigatran etexilate capsules

JOHNS HOPKINS
HEALTH PLANS
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):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. **The brand Pradaxa capsule formulation is the preferred product over generic dabigatran capsules and is covered at the lowest copayment, which is the generic formulary copayment for non-Active Duty patients, and at no cost share for Active Duty patients. (Although Pradaxa capsules are a branded product, it will be covered at the generic formulary copayment or cost share) Please type "Acknowledge" and proceed to the next question.**	_____ Proceed to question **2**
2. **Please provide a patient-specific justification as to why the brand Pradaxa capsules cannot be used in this patient.**	_____ **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

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