TRICARE Prior Authorization Request Form for
nitisinone (Harliku tablets)

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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.

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 Harliku 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 nitisinone 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?	☐ Alkaptonuria (AKU) – Proceed to question 5 ☐ Other diagnosis – **STOP – Coverage not approved**	

5. Please provide a clinical rationale why the patient cannot take formulary alternatives including generic nitisinone 2 mg 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 _____