TRICARE Prior Authorization Request Form for
sirolimus 0.2% gel **(Hyftor)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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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.

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. Is the requested medication prescribed by or in consultation with a dermatologist or other provider experienced in tuberous sclerosis treatment?	☐ Yes Proceed to question 2	☐ No **STOP** Coverage not approved
2. Does the patient have a documented diagnosis of facial angiofibroma associated with Tuberous Sclerosis Complex (TSC)?	☐ Yes Proceed to question 3	☐ No **STOP** Coverage not approved
3. Does the provider acknowledge the recommendation to monitor for hyperlipidemia during treatment?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

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

_____ _____
Prescriber Signature Date

[15 February 2023]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#: