TRICARE Prior Authorization Request Form for
Insulin degludec (Tresiba), insulin degludec (unbranded)

JOHNS HOPKINS
HEALTH PLANS
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.

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 Lantus is the DoD's preferred basal insulin and preferred insulin glargine. No prior authorization is required for Lantus. Lantus is available at the lowest Tier 1 copy.	☐ Acknowledged Proceed to question **2**	
2. Is the patient greater than or equal to 1 year of age?	☐ **Yes** **Proceed to question 3**	☐ **No** **STOP** **Coverage not approved**
3. Has the patient tried and had an inadequate response to insulin glargine (Lantus)?	☐ **Yes** **Proceed to question 4**	☐ **No** **STOP** **Coverage not approved**
4. Please explain why the patient cannot use Lantus.	Fill in the blank: **Proceed to question 5**	

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5. Please explain why the patient cannot use Toujeo.	Fill in the blank: **Proceed to question 6**
6. What is the requested medication?	☐ Tresiba – **Proceed to question 7** ☐ Insulin degludec (unbranded) - **Sign and date below** ☐ Other – **STOP - Coverage not approved**
7. Please explain why the patient cannot use unbranded insulin degludec.	Fill in the blank: **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

[30 October 2024]

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