TRICARE Prior Authorization Request Form for
hydrocortisone oral solution (Khindivi)

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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.

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. How old is the patient?	☐ Less than 5 years of age – **STOP – Coverage not approved** ☐ 5 to 18 years of age – Proceed to question **2** ☐ 19 years of age or older – **STOP – Coverage not approved**	
2. Provider acknowledges that the following products are available without a prior authorization: 5 mg generic hydrocortisone tablets, hydrocortisone 100 mg act-O-vials, and prednisone intensol oral solution. Please consider changing the prescription to one of these agents.	☐ Acknowledged Proceed to question **3**	
3. Is the patient using Khindivi as replacement therapy for adrenocortical insufficiency?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the provider acknowledge that the patient's dosing regimen requires small doses of hydrocortisone and cannot accurately split the dose using 5 mg hydrocortisone tablets?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**

5. Please provide a clinical rationale as to why this agent is required and patient cannot take generic hydrocortisone tablets, Alkindi Sprinkle, hydrocortisone 100 mg act-O-vials, and prednisone intensol oral solution.	_____ **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 July 2026]

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