TRICARE Prior Authorization Request Form for Basal Insulin Analogs: Levemir/Levemir FlexPen/Levemir FlexTouch

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. Does the provider acknowledge that insulin glargine (Lantus) is the Department of Defense's preferred basal insulin and is available without a prior authorization (PA) at the lowest Tier 1 copay?	☐ **Yes** **Proceed to question 2**	☐ **No** **STOP** **Coverage not approved**
2. Does the provider acknowledge that branded Levemir will be discontinued from the market in 2024?	☐ **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** **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

[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: