TRICARE Prior Authorization Request Form for
baclofen oral suspension **(Fleqsuvy),** baclofen oral solution **(Ozobax, Ozobax DS)**

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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. For which indication is the requested medication being prescribed? Note: Non-FDA-approved uses are not approved including nystagmus, trigeminal neuralgia, hiccups, GERD, alcohol abstinence in alcoholic liver disease, and low back pain.	☐ Treatment of spasticity– Proceed to question **2** ☐ Other – **STOP Coverage not approved**	
2. Is the patient unable to use the tablet formulation or crushed tablet due to a documented medical condition such as dysphagia, oral candidiasis, or systemic sclerosis, and not due to convenience? Note: Presence of a nasogastric (NG) tube/J-tube alone are not reasons for approval.	☐ 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

[1 Dec 2023]

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