TRICARE Prior Authorization Request Form for
omaveloxolone (Skyclarys)

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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. Is the patient greater than or equal to 16 years of age?	☐ Yes **Proceed to question 2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication prescribed by a neurologist?	☐ Yes **Proceed to question 3**	☐ No **STOP** **Coverage not approved**
3. Does the patient have genetic testing confirming the diagnosis of Friedreich's Ataxia?	☐ Yes **Proceed to question 4**	☐ No **STOP** **Coverage not approved**
4. Is the provider aware of the warnings, screening and monitoring precautions for Skyclarys?	☐ 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 Nov 2023]

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