

TRICARE Prior Authorization Request Form for
Sofpironium Bromide (Sofdra)



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.

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 9 years of age or older?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Is the requested medication prescribed by a dermatologist?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. What is the indication or diagnosis? Note: This medication is NOT for the treatment of palmar, plantar, facial, or other forms of hyperhidrosis.	<input type="checkbox"/> Primary axillary hyperhidrosis for greater than or equal to 6 months - Proceed to question 4 <input type="checkbox"/> Other diagnosis – STOP Coverage not approved	
4. Has the patient tried and failed AT LEAST ONE topical 20% or higher aluminum salt antiperspirant (either OTC or prescription; for example, Drysol)?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
5. Has the patient tried and failed AT LEAST TWO additional options (for example, Botox, MiraDry, iontophoresis, oral anticholinergics [glycopyrrolate, oxybutynin, propantheline], propranolol, clonidine or diltiazem)?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> 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

[12 February 2025]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: _____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: