TRICARE Prior Authorization Request Form for
tiotropium bromide **(Spiriva Handihaler)**

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USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

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. The provider acknowledges that Spiriva Respimat is the DoD's preferred long-acting muscarinic inhaler. Spiriva Respimat does not require PA.	☐ Acknowledged Proceed to question **2**	
2. Please provide a patient-specific reason as to why the patient cannot use Spiriva Respimat.	_____ Proceed to question **3**	
3. Which medication is being requested?	☐ Spiriva Handihaler **Sign and date below**	☐ Tiotropium Bromide (generic Spiriva Handihaler) Proceed to question **4**
4. The provider acknowledges that brand Spiriva Handihaler is DoD's preferred product over generic Tiotropium Bromide and is covered at the lowest (generic) copayment. Note that PA still applies to Spiriva Handihaler brand; no PA is required for Spiriva Respimat.	☐ Acknowledged Proceed to question **5**	

5. Please provide a patient-specific justification as to why brand Spiriva Handihaler cannot be used in this patient.	_____ **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

[20 October 2023]

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