Prior Authorization Request Form for
levothyroxine sodium solution (**Tirosint-SOL**)

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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. Is the patient less than 6 years of age?** | ☐ Yes **STOP** **Prior Authorization Not Required** | ☐ No Proceed to question **2** |
| **2. Is the patient able to chew a levothyroxine tablet?** | ☐ Yes **STOP** **Coverage not approved** | ☐ No Proceed to question **3** |
| **3. Is the patient able to swallow a capsule or tablet?** | ☐ Yes **STOP** **Coverage not approved** | ☐ No Proceed to question **4** |
| **4. Is the requested medication being prescribed by or in consultation with an endocrinologist?** | ☐ 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

**[14 August 2019]**

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