

TRICARE Prior Authorization Request Form for
sitagliptin (Zituvio), sitagliptin-metformin (Zituvimet/Zituvimet XR)



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.

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:

<p>1. Provider acknowledges that Januvia and its combination products are DoD's preferred dipeptidyl peptidase-4 inhibitors and are available to TRICARE beneficiaries without requiring prior authorization. Please type "acknowledged" to proceed.</p>	<p><input type="checkbox"/> Acknowledged Proceed to question 2</p>
<p>2. Please document why the patient cannot use the brand Januvia or Janumet or Janumet XR.</p>	<p>_____ Sign and date below</p>

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

_____	_____
Prescriber Signature	Date

[22 October 2024]

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: