

# Prior Authorization Request Form for Cycloset (bromocriptine)



5651

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

MAIL ORDER and RETAIL	<ul style="list-style-type: none"> <li>The provider may <b>call: 1-866-684-4488</b> or the completed form may be <b>faxed to:</b> <b>1-866-684-4477</b></li> <li>The patient may attach the completed form to the prescription and <b>mail</b> it to: <b>Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954</b> or <b>email</b> the form only to: <b>TPharmPA@express-scripts.com</b></li> </ul>
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Prior authorization criteria and a copy of this form are available at: [http://pec.ha.osd.mil/forms\\_criteria.php](http://pec.ha.osd.mil/forms_criteria.php). This prior authorization has no expiration date.

**Step 1** Please complete patient and physician information (please print):

Patient Name: _____ Address: _____ Sponsor ID #: _____ Date of Birth: _____	Physician Name: _____ Address: _____ Phone #: _____ Secure Fax #: _____
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**Step 2** Please complete the clinical assessment:

1. Does the patient have a confirmed diagnosis of type 2 diabetes mellitus?	Yes Proceed to question 2	No <b>STOP</b> Coverage not approved
2. Has the patient experienced any of the following adverse events while receiving metformin: impaired renal function that precludes treatment with metformin or a history of lactic acidosis?	Yes Sign and date below	No Proceed to question 3
3. Has the patient experienced the following adverse event while receiving a sulfonylurea: hypoglycemia requiring medical treatment?	Yes Sign and date below	No Proceed to question 4
4. Does the patient have a contraindication to BOTH metformin and a sulfonylurea?	Yes Sign and date below	No Proceed to question 5
5. Has the patient tried BOTH of the following and failed to achieve glycemic control: <b>METFORMIN</b> (alone or in a combination product) and a <b>SULFONYLUREA</b> (alone or in a combination product)?	Yes Sign and date below	No Coverage not approved

**Step 3** I certify the above is true to the best of my knowledge.

Please sign and date:

\_\_\_\_\_

Prescriber Signature

\_\_\_\_\_

Date