

Prior Authorization Request Form for Janumet, Kombiglyze XR



5649

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"> The provider may call: 1-866-684-4488 or the completed form may be faxed to: 1-866-684-4477 The patient may attach the completed form to the prescription and mail it to: Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954 or email the form only to: TPHarmPA@express-scripts.com
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Prior authorization criteria and a copy of this form are available at: 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):

1	Patient Name: _____	Physician Name: _____
	Address: _____	Address: _____
	_____	_____
	Sponsor ID #: _____	Phone #: _____
	Date of Birth: _____	Secure Fax #: _____

Step 2 Please complete the clinical assessment:

2	1. Has the patient tried at least ONE of the following and failed to achieve glycemic control: METFORMIN (alone or in combination) or a SULFONYLUREA (alone or in combination)?	Yes Sign and date below	No Proceed to question 2
	2. 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 3
	3. Does the patient have a contraindication to a sulfonylurea?	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