

Prior Authorization Request Form for Januvia, Juvisync, Onglyza, Tradjenta (DPP-4 inhibitors)



5650

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):

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. 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 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 Coverage not approved

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

Please sign and date:

Prescriber Signature

Date