TRICARE Prior Authorization Request Form for
Medications Subject to Non-Federal Ceiling Price Requirements
Filled at Network Retail Pharmacies

5678

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 Retail Pharmacy Program (TRRx) at retail pharmacies. Express Scripts is the TRRx contractor for DoD.

The law governing the Department of Defense (DoD) TRICARE Pharmacy Benefit Program requires drug companies to provide discounted drug prices for DoD beneficiaries' prescriptions filled at retail pharmacies. When drug companies choose not to provide discounts required by law, their products can be placed in a special non-formulary class. The beneficiary will have to pay 100 percent of the cost of medications in this special non-formulary class if the prescription is filled at a retail pharmacy without preauthorization. However, the beneficiary will still be able to fill the prescription for the current non-formulary cost share for up to a 90-day supply through the TRICARE Mail Order Pharmacy, also known as Home Delivery.

PLEASE NOTE: For Active Duty Service Members, even if coverage will NOT BE APPROVED per this form, it still must be initially submitted to the TPharm Contractor for review. Subsequent reconsideration is allowed at the appropriate Military Treatment Facility.

For initial review by the TPharm Contractor;
- 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

The PA criteria listed below do not apply to any point of service other than retail network pharmacies.

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. Please answer all questions and provide an explanation for any "Yes" response.

Drug for which Prior Authorization is requested: _____

1. Is use of a formulary agent contraindicated?	☐ **Yes** – **Provide explanation** and proceed to question 2	☐ **No** Proceed to question 2
2. Would obtaining the product from Home Delivery be detrimental to the patient?	☐ **Yes** – **Provide explanation** and proceed to question 3	☐ **No** Proceed to question 3
3. If the requested agent is a branded product with an A-rated generic available, would use of the generic product be detrimental to the patient?	☐ **Yes** – **Provide explanation** and sign/date below	☐ **No** Sign and date below

Step 3

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

_____ _____
Prescriber Signature Date

[27 June 2012]