

# Medications Subject to Non-Federal Ceiling Price Requirements Filled at Network Retail Pharmacies

## Prior Authorization Request Form



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.

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></ul>
	<ul style="list-style-type: none"><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>

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):

<b>1</b>	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?	<input type="checkbox"/> <b>Yes</b> – Provide explanation and proceed to question 2	<input type="checkbox"/> <b>No</b> Proceed to question 2
2. Would obtaining the product from Home Delivery be detrimental to the patient?	<input type="checkbox"/> <b>Yes</b> – Provide explanation and proceed to question 3	<input type="checkbox"/> <b>No</b> Proceed to question 3
3. If the requested agent is a branded product with AB generic availability, would use of the generic product be detrimental to the patient?	<input type="checkbox"/> <b>Yes</b> – Provide explanation and sign/date below	<input type="checkbox"/> <b>No</b> 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