TRICARE Prior Authorization Request Form for
Ozempic, Mounjaro

6740

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.

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

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:

1. Trulicity is available to TRICARE beneficiaries at a lower copay than Ozempic or Mounjaro. Trulicity also has an indication to reduce the risk of major adverse cardiovascular events in adults with Type 2 diabetes mellitus (T2DM) who have established cardiovascular disease or multiple cardiovascular risk factors; Mounjaro does not have this indication.	☐ Acknowledged Proceed to question **2**	
2. Does the patient have a diagnosis of type 2 diabetes mellitus?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. Has the patient tried metformin (alone or in combination) and failed to achieve blood sugar control?	☐ Yes **Sign and date below**	☐ No Proceed to question **4**
4. 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 **5**
5. Does the patient have a contraindication to metformin?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

Step 3

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

_____ _____

Prescriber Signature Date

[09 November 2022]