# TRICARE Prior Authorization Request Form for Trulicity

5694

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. Does the patient have a diagnosis of type 2 diabetes mellitus?** | ☐ Yes<br>Proceed to question 2 | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **2. Has the patient tried metformin (alone or in combination) and failed to achieve blood sugar control?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>Proceed to question 3 |
| **3. Has the patient experienced any of the following adverse events that precludes treatment with metformin: impaired renal function or a history of lactic acidosis?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>Proceed to question 4 |
| **4. Does the patient have a contraindication to metformin?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**STOP**<br>**Coverage not approved** |

**Step 3** **I certify the above is true to the best of my knowledge.**
Please sign and date:

Prescriber Signature _____ Date _____

[28 September 2022]