TRICARE Prior Authorization Request Form for
Insulin glargine **(Basaglar Tempo)**

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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

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. **Provider acknowledges that Lantus is the DoD's preferred basal insulin and preferred insulin glargine. No prior authorization is required for Lantus. Lantus is available at the lowest Tier 1 copay.**	☐ Acknowledged Proceed to question **2**	
2. **Has the patient tried and failed Lantus?**	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. **Please document why the patient cannot use the Basaglar Kwikpen version.**	_____ **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

[06 January 2023]