TRICARE Prior Authorization Request Form for
birch triterpenes (Filsuvez)

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HEALTH PLANS
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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.

Initial therapy approves for 6 months, renewal approves for 12 months. For renewal of therapy an initial Tricare prior authorization approval is required.

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. Is the requested medication prescribed by a dermatologist or wound care specialist?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication.*	☐ Yes (subject to verification) Proceed to question **7**	☐ No **Proceed to question 3**
3. Is the patient 6 months of age or older?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. What is the indication or diagnosis?	☐ Dystrophic epidermolysis bullosa (DEB) - Proceed to question **5** ☐ Junctional epidermolysis bullosa (JEB) - Proceed to question **5** ☐ Other – **STOP Coverage not approved**	
5. Does the patient have one or more open wounds that will be treated?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Is the patient's wound clean in appearance and does not appear to be infected?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

7. Has the patient had disease stabilization or improvement in disease on therapy?	☐ 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 _____

[14 Aug 2024]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: