TRICARE Prior Authorization Request Form for
Insulin glargine 300 U/mL **(Toujeo, Insulin Glargine Solostar, Insulin Glargine Max Solostar)**

7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

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

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:**

Question	Yes	No
1. Is the patient 6 years old or older?	☐ Yes Proceed to question **2**	☐ No **STOP Coverage not approved**
2. Does the patient have diabetes?	☐ Yes Proceed to question **3**	☐ No **STOP Coverage not approved**
3. Is the patient using a minimum of 100 units of Lantus (insulin glargine) per day?	☐ Yes Proceed to question **4**	☐ No **STOP Coverage not approved**
4. Does the patient require a dosage increase with Lantus?	☐ Yes Proceed to question **5**	☐ No **STOP Coverage not approved**
5. Has the patient experienced a clinically significant severe hypoglycemia episode, despite splitting the Lantus dose?	☐ Yes Proceed to question **6**	☐ No **STOP Coverage not approved**
6. Has the patient, parent, or caregiver been counseled regarding the risk of dosing errors?	☐ Yes **Sign and date below**	☐ No **STOP Coverage not approved**

Note: The following are not acceptable reasons for prior authorization of Toujeo, Insulin Glargine Solostar, or Insulin Glargine Max Solostar:

- Non-adherence to previous insulin treatment
- Patient or prescriber preference for the use of Toujeo, Insulin Glargine Solostar, or Insulin Glargine Max Solostar
- Patient or prescriber preference for a smaller injection volume

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

______________________ Prescriber Signature ______________ Date

[14 February 2024]

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