TRICARE Prior Authorization Request Form for hydroxychloroquine **(Plaquenil)**

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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.

- 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. Please provide the indication for use. **Note: Hydroxychloroquine is NOT approved for use for corona virus disease 2019 (COVID-19) prophylaxis or outpatient treatment. This PA does not apply to or affect inpatient use.**	_____ Proceed to question **2**	
2. Is the requested medication prescribed for an FDA-approved indication? Note: FDA-approvable indications include: malaria, malaria prophylaxis, rheumatoid arthritis (RA), chronic discoid erythematosus and systemic lupus erythematosus (SLE).	☐ Yes Proceed to question **3**	☐ No Proceed to question **4**
3. What is the FDA-approved indication?	☐ Malaria/Malaria prophylaxis - **Sign and date below** ☐ Rheumatoid arthritis (RA) - **Sign and date below** ☐ Chronic discoid erythematosus or systemic lupus erythematosus (SLE). - **Sign and date below** ☐ Other – **STOP coverage not approved**	
4. Is the requested medication prescribed by or in consultation with an Infectious Diseases (ID) provider?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is the indication for use supported by applicable published guidance by FDA, CDC, NIH, IDSA justifying the clinical decision for the off-label prescribing for COVID-19?	☐ 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

[03 April 2020]