TRICARE Prior Authorization Request Form for
glipizide 2.5mg IR tablet

6901

To be completed and signed by the prescriber.

MARTIN'S POINT® HEALTHCARE

Clinical Documentation is required for a determination to be made.

Please fax completed form back to: (207) 828-7816

Prior authorization does not expire.

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 other formulations of glipizide are available without prior authorization.	☐ Acknowledged Proceed to question **2**
2. Please explain why the patient requires glipizide 2.5 mg tablets and cannot take the cost-effective generic glipizide formulations.	_____ 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

[26 June 2024]