TRICARE Prior Authorization Request Form for potassium chloride 10 mEq packet (Pokonza)



6900

To be completed and signed by the prescriber.



Clinical Documentation is required for a determination to be made.

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

Filoi auti	Filor authorization does not expire.			
Step	Please complete patient and physician information (please print):			
		nysician Name:		
	Address:	Address:		
	Sponsor ID #	Phone #:		
	Date of Birth:	Secure Fax #:		
Step 2	Please complete the clinical assessment:			
	Provider acknowledges other strengths and formulat of potassium chloride are available without prior	ions	☐ Acknowledged	
	authorization.		Proceed to question 2	
	2. Please explain why the patient requires Pokonza and cannot take the cost-effective generic potassium chloride 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	Da	te	
			[26 June 2024]	