Prior Authorization Criteria for: Qualaquin (quinine sulfate)

Background
Quinine sulfate (Qualaquin) is FDA approved only for the treatment of malaria, alone or in combination with other agents. Use of quinine sulfate for prevention of malaria is not recommended. Use of quinine sulfate for prevention of leg cramps is an off-label use that is both not supported by the clinical evidence and not covered by TRICARE.

The following criteria were established by the DoD Pharmacy & Therapeutics (P&T) Committee.

Prior Authorization Criterion for Quinine sulfate (Qualaquin)
Coverage is approved if:
1. The patient has a diagnosis of malaria requiring treatment with quinine sulfate and the patient has been informed of the risks and benefits of treatment with quinine sulfate.

Criterion approved through the DoD P&T Committee process May 2010

www.tricare.mil is the official Web site of the TRICARE Management Activity, a component of the Military Health System
Skyline 5, Suite 810, 5111 Leesburg Pike, Falls Church, VA 22041-3206
Qualaquin (quinine sulfate)
US Family Health Plan Prior Authorization Request Form

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).

MAIL ORDER

and RETAIL

- The provider may call: 1-877-880-7007
  or the completed form may be faxed to: 1-617-562-5296
- The patient may attach the completed form to the prescription and mail it to: ATTN: Pharmacy, 77 Warren St, Brighton, MA 02135

Prior authorization criteria and a copy of this form are available at: [Redacted].

Expiration date.

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).

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:
Is Qualaquin being used to treat malaria?  ☐ Yes  ☐ No
Please sign and date

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

Prescriber Signature: ______________________  Date: ______________________

Implementation: 6 October 2010