

# US Family Health Plan Pharmacy Program

## Paxil CR, Prozac Weekly, and Sarafem Medical Necessity Form

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This form applies to the US Family Health Plan Mail Order Pharmacy and the US Family Health Plan Retail Pharmacy programs. This form must be completed and signed by the prescriber.

- Formulary alternatives for these medications include: bupropion immediate-/sustained-/extended-release, fluoxetine, paroxetine immediate-release, citalopram, sertraline, venlafaxine immediate-release/Effexor XR/venlafaxine ER, mirtazapine, and nefazodone.
- Paxil CR/paroxetine CR, Prozac Weekly, and Sarafem are non-formulary, but available to most beneficiaries at a \$22 cost share. Other non-formulary antidepressants are Cymbalta, Lexapro, and Pristiq.
- You do NOT need to complete this form in order for non-active duty beneficiaries (spouses, dependents, and retirees) to obtain non-formulary medications at the \$22 non-formulary cost share. The purpose of this form is to provide information that will be used to determine if the use of a non-formulary medication instead of a formulary medication is medically necessary. If a non-formulary medication is determined to be medically necessary, non-active duty beneficiaries may obtain it at the \$9 formulary cost share.

<b>MAIL ORDER</b>	<b>If the prescription is to be filled through the USFHP Mail Order Pharmacy, check here</b> <input type="checkbox"/>	<b>RETAIL</b>	<b>If the prescription is to be filled at a retail pharmacy, check here</b> <input type="checkbox"/>
	<ul style="list-style-type: none"> <li>The completed form and the prescription may be <b>faxed to 1-617-562-5296</b> OR</li> <li>The patient may attach the completed form to the prescription and <b>mail it to: Attn: Pharmacy, 77 Warren Street, Brighton, MA 02135</b></li> </ul>		<ul style="list-style-type: none"> <li>The provider may <b>call: 1-877-880-7007</b></li> <li style="text-align: center;">OR</li> <li>The completed form may be <b>faxed to 1-617-562-5296</b></li> </ul>

**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** Paxil CR (paroxetine controlled release)

Please explain why the patient cannot be treated with any of the formulary agents listed below, including the formulary version of this product (paroxetine immediate-release). A specific explanation is required for each formulary agent.

Formulary Agent	Reason	Explanation
paroxetine immediate release	1 2 3 4 5	
citalopram	1 2 3 4 5	
fluoxetine	1 2 3 4 5	
sertraline	1 2 3 4 5	

1. The formulary agent is contraindicated (e.g., due to hypersensitivity to the agent or an inert ingredient).
2. The patient has experienced significant adverse effects with the formulary agent, but is expected to tolerate Paxil CR.
3. An adequate trial of the formulary agent resulted in therapeutic failure, but the patient is expected to respond to Paxil CR.
4. The patient has previously responded to Paxil CR and changing to a formulary agent would incur unacceptable risk (e.g., risk of destabilization).
5. The patient is likely to experience intolerable adverse effects when starting therapy with paroxetine immediate release due to predisposing factors for nausea (e.g., chemotherapy, GI disorder).

**Questions for Prozac Weekly and Sarafem are on Page 2. For all products, please sign and date at the bottom of Page 2 (Step 3).**

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## Paxil CR, Prozac Weekly, and Sarafem Medical Necessity Form

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**Step Prozac Weekly** (fluoxetine 90-mg capsules for weekly dosing for the maintenance of response in depression)

**2** Please explain why the patient cannot be treated with any of the formulary agents listed below, including the formulary version of this product (generic fluoxetine given daily). A specific explanation is required for each formulary agent.

Formulary Agent	Reason	Explanation
fluoxetine	1 2 3 4	
citalopram	1 2 3 4	
paroxetine immediate release	1 2 3 4	
sertraline	1 2 3 4	

1. The formulary agent is contraindicated (e.g., due to hypersensitivity to the agent or an inert ingredient).
2. The patient has experienced significant adverse effects with the formulary agent, but is expected to tolerate Prozac Weekly.
3. An adequate trial of the formulary agent resulted in therapeutic failure, but the patient is expected to respond to Prozac Weekly.
4. The patient has previously responded to Prozac Weekly and changing to a formulary agent would incur unacceptable risk (e.g., risk of destabilization).

**Sarafem** (fluoxetine 10- or 20-mg capsules in special packaging for treatment of premenstrual dysphoric disorder [PMDD])

Please explain why the patient cannot be treated with the formulary version of this product or with sertraline, which is also FDA-approved for the treatment of PMDD. A specific explanation is required for each formulary agent.

Formulary Agent	Reason	Explanation
fluoxetine	1 2 3 4	
sertraline	1 2 3 4	

1. The formulary agent is contraindicated (e.g., due to hypersensitivity to the agent or an inert ingredient).
2. The patient has experienced significant adverse effects with the formulary agent, but is expected to tolerate Sarafem.
3. An adequate trial of the formulary agent resulted in therapeutic failure, but the patient is expected to respond to Sarafem.
4. The patient has previously responded to Sarafem and changing to a formulary agent would incur unacceptable risk (e.g., risk of destabilization).

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

**3**

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date