

US Family Health Plan Pharmacy Program

Ambien CR, Edluar, Rozerem, and Sonata Medical Necessity Form

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.

- Newer sedative hypnotic agents on the DoD Uniform Formulary include zolpidem immediate release (Ambien) and eszopiclone (Lunesta). Zolpidem extended release (Ambien CR), zolpidem sublingual tablets (Edluar), ramelteon (Rozerem), and zaleplon (Sonata) are non-formulary, but available to most beneficiaries at a \$22 cost share. Please note that prior authorization (PA) requirements apply to all drugs in this class except zolpidem immediate release (Ambien). PA forms are available on the US Family Health Plan website at http://www.usfamilyhealth.org/fdownloadable_forms.html This Medical Necessity form may NOT be used to meet PA requirements.
- 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 either of the formulary medications is medically necessary. If a non-formulary medication is determined to be medically necessary AND the non-active duty beneficiary has met PA requirements, it will be available at the \$9 formulary cost share rather than the \$22 non-formulary cost share.

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

Step 1 Please complete patient and physician information (Please Print)

1	Patient Name: _____	Physician Name: _____
	Address: _____	Address: _____
	Sponsor ID: _____	Phone #: _____
	Date of Birth: _____	Secure Fax: _____

Step 2. Please indicate which medication is being prescribed:

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- Ramelteon (Rozerem)
 - Zaleplon (Sonata)
 - Zolpidem extended-release (Ambien CR)
 - Zolpidem sublingual tablets (Edluar)

2. Please explain why the patient cannot be treated with either of the formulary medications:

Please indicate which of the reasons below (1-4) applies to each of the formulary medications listed in the table. You **MUST** circle a reason AND supply a written clinical explanation specific for EACH formulary medication.

Formulary Medication	Reason	Clinical Explanation
Zolpidem immediate release (Ambien)	1 2 3 4 5	
Eszopiclone (Lunesta)	1 2 3 4 5	

Acceptable clinical reasons for not using a formulary medication are:

1. Use of the formulary medication is contraindicated (e.g., due to hypersensitivity).
2. The patient has experienced or is likely to experience significant adverse effects from the formulary medication.
3. Use of the formulary medication has resulted in therapeutic failure.
4. (Rozerem only) Rozerem, which is a non-controlled drug with a mechanism of action different from other newer sedative hypnotics, is the most clinically suitable choice for this patient due to its apparent lack of abuse potential.
5. (Edluar only) The patient is unable to swallow or has difficulty swallowing.

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

3

Prescriber Signature

Date