

US Family Health Plan Pharmacy Program Medical Necessity Form for Dihydropyridine Calcium Channel Blockers

This form applies to the US Family Health Plan. The form must be completed and signed by the prescriber.

- Amlodipine, felodipine, nifedipine, and generic nisoldipine (Sular core coat delivery system) are the dihydropyridine calcium channel blockers (CCBs) included on the DoD Uniform Formulary. Isradipine (immediate- and extended-release [Dynacirc CR]), nicardipine (immediate- and sustained-release [Cardene SR]), and Sular (Geomatrix delivery system) are non-formulary, but available to most beneficiaries at a \$22 cost share.
- 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.

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

- 2** Please explain why the patient cannot be treated with any of the formulary alternatives: Please indicate which of the reasons below (1-4) applies to each of the formulary alternatives listed in the table. You **MUST** circle a reason AND supply a written clinical explanation specific for EACH formulary alternative.

Formulary Alternative	Reason	Clinical Explanation
Amlodipine (Norvasc)	1 2 3 4	
Felodipine (Plendil)	1 2 3 4	
Nifedipine extended release (e.g., Procardia XL, Adalat CC)	1 2 3 4	
Nisoldipine core coat (Sular core coat)	1 2 3 4	

1. The formulary alternative is contraindicated (e.g., due to hypersensitivity).
2. The patient has experienced significant adverse effects with the formulary alternative.
3. Use of the formulary alternative resulted in therapeutic failure.
4. The patient is stabilized on a non-formulary CCB, is clinically fragile (multiple comorbidities), and changing to a formulary alternative would incur an unacceptable risk to the patient (e.g., destabilization, abrupt worsening of symptoms).

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

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Prescriber Signature

Date