

US Family Health Plan Pharmacy Program Medical Necessity Form for CalciumChannel Blockers— Non-dihydropyridines (Verelan, Verelan PM, Covera HS, and Cardizem LA)

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

- Long-acting verapamil and diltiazem products on the DoD Uniform Formulary are verapamil sustained release (e.g., Isoptin SR) and diltiazem sustained and extended release (e.g., Diltia XR, Cartia XR, Taztia XT). The following products are non-formulary, but available to most beneficiaries at a \$22 cost share: Verelan (verapamil extended release); Verelan PM and Covera HS (verapamil extended release for bedtime dosing); and Cardizem LA (diltiazem extended release for bedtime dosing).
- 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 OR The completed form may be faxed to 1-617-562-5296

There is no expiration date for approved medical necessity determinations.

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 the formulary medication:

1. Verelan, Verelan PM, or Covera HS is required because use of all other verapamil long-acting products is contraindicated (e.g., due to hypersensitivity to a dye or other inert ingredient), and treatment with Verelan, Verelan PM, or Covera HS is not contraindicated. Please explain below:	<input type="checkbox"/>
2. Cardizem LA is required because use of all other diltiazem long-acting products is contraindicated (e.g., due to hypersensitivity to a dye or other inert ingredient), and treatment with Cardizem LA is not contraindicated. Please explain below:	<input type="checkbox"/>
3. The patient is stabilized on a non-formulary medication (Verelan, Verelan PM, Covera HS, or Cardizem LA), is clinically fragile (multiple comorbidities), and changing to a formulary verapamil or diltiazem product would incur an unacceptable risk to the patient (e.g., destabilization, abrupt worsening of symptoms). Please explain below:	<input type="checkbox"/>

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