

US Family Health Plan Pharmacy Program Medical Necessity Form for Inhaled Corticosteroids (ICSS)

This form applies to the US Family Health Plan Mail Order Pharmacy and the US Family Health Plan Retail Pharmacy Program and may be found on the US Family Health Plan Pharmacy website at www.usfamilyhealthplan.org. The form must be completed and signed by the prescriber.

- **Budesonide inhalation solution (Pulmicort Respules, generic), fluticasone HFA MDI (Flovent HFA), fluticasone DPI (Flovent Diskus), and mometasone DPI (Asmanex Twisthaler) are the inhaled corticosteroids on the DoD Uniform Formulary. Beclomethasone HFA MDI (QVAR), budesonide DPI (Pulmicort Flexhaler), ciclesonide HFA MDI (Alvesco), flunisolide CFC MDI (AeroBid, AeroBid-M), and triamcinolone CFC MDI (Azmacort) 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 nonformulary 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 1. Please indicate which inhaled corticosteroid is being requested:

2 _____

2. Please explain why the patient cannot be treated with a formulary medication:

Please indicate which of the reasons below (1-3) applies to each of the formulary medications listed in the table.

You **MUST** circle a reason **AND** supply a specific written clinical explanation for **EACH** formulary medication.

Formulary Medication	Reason	Clinical Explanation
Asmanex Twisthaler (mometasone DPI)	1 2 3	
Budesonide inhalation solution (Pulmicort, generics)	1 2 3	
Flovent HFA (fluticasone HFA MDI)	1 2 3	
Flovent Diskus (fluticasone DPI)	1 2 3	

1. Use of the formulary medication is contraindicated (e.g., due to hypersensitivity).

2. The formulary medication has resulted in or is likely to result in therapeutic failure.

3. No alternative formulary medication is available. This reason applies specifically to budesonide, which is classified as FDA pregnancy risk category B.

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

3

_____ Prescriber Signature

_____ Date