# US Family Health Plan Medical Necessity Form for Ketek (telithromycin) and Zmax (azithromycin sustained release suspension)

This form applies to the US Family Health Plan Mail Order Pharmacy and Retail Pharmacy Programs and may be found on the US Family Health Plan Pharmacy website at http://www.usfamilyhealthplan.org/facility/site_content.asp?s=110. The medical necessity criteria outlined on this form also apply at the Brighton Marine Health Center Pharmacies in Brighton, MA and Hanscom AFB, MA. The form must be completed and signed by the prescriber.

- **Formulary macrolide/ketolide antibiotics** on the DoD Uniform Formulary **include: all azithromycin products except for Zmax, clarithromycin, and erythromycin.** Ketek (telithomycin) and Zmax (azithromycin sustained release suspension) 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.

| Complete this form and submit it with the prescription to US Family Health Plan by **EITHER**:<br><br>**Fax:** 1-617-562-5296<br>**OR**<br>**Mail:** US Family Health Plan<br>Attn: Pharmacy<br>77 Warren Street<br>Boston, MA 02135 | Please indicate whether the prescription is to be filled:<br><br>☐ through the US Family Health Plan Mail Order Pharmacy<br>**OR**<br>☐ at a retail network pharmacy |
|---|---|

There is no expiration date for approved medical necessity determinations.

## Step 1

**Please complete patient and physician information** (Please Print)

Patient Name: ______________________ Physician Name: ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

Sponsor ID # ______________________ Phone #: ______________________

Secure Fax #:

## Step 2

**Ketek: 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 |
|---|---|---|
| Azithromycin (except Zmax) | 1 2 3 4 | |
| Clarithromycin | 1 2 3 4 | |
| Erythromycin | 1 2 3 4 | |

**Acceptable clinical reasons for not using a formulary alternative are:**

1. The formulary alternative is contraindicated (e.g. due to a hypersensitivity reaction).
2. The patient has experienced significant adverse effects with the formulary alternative.
3. Use of the formulary alternative has resulted in therapeutic failure or is likely to result in therapeutic failure (e.g., due to lack of activity against a particular organism) AND Ketek therapy is appropriate.
4. The patient cannot be treated with a formulary alternative due to recent history of documented multi-drug resistant *S. pneumoniae* AND use of other formulary antibiotics (e.g., fluoroquinolones, high dose aminopenicillins) is not appropriate.

**Zmax: Please explain why the patient cannot be treated with a formulary azithromycin product (250 or 500mg tablets or immediate release suspension):**

Use of ALL other azithromycin products (250 or 500mg tablets or immediate release suspension) is contraindicated (e.g., hypersensitivity to a dye or other inert ingredient), and treatment with Zmax sustained release suspension is not contraindicated. Please provide a clinical explanation in the space below: ☐

______________________________________________

______________________________________________

## Step 3

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

______________________________ ______________

Prescriber Signature Date

Latest revision: January 2006