

US Family Health Plan Medical Necessity Form for Lexapro (escitalopram)

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 antidepressants include citalopram, fluoxetine, paroxetine immediate release, and Zoloft (sertraline); bupropion immediate /sustained release, Effexor / Effexor XR (venlafaxine), mirtazapine, and nefazodone.
- Lexapro is non-formulary, but available to most beneficiaries at a \$22 cost share. Other non-formulary antidepressants are Cymbalta, Paxil CR, Prozac Weekly, Sarafem, and Wellbutrin XL.
- You do **NOT** need to complete this form in order for non-active duty beneficiaries (spouses, dependents, and retirees) to obtain Lexapro 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 Lexapro *instead of a formulary medication* is medically necessary. If Lexapro is determined to be medically necessary, non-active duty beneficiaries may obtain it at the \$9 formulary cost share.

<p>Complete this form and submit it with the prescription to US Family Health Plan by EITHER:</p> <p>Fax: 1-617-562-5296 OR</p> <p>Mail: US Family Health Plan Attn: Pharmacy 77 Warren Street Boston, MA 02135</p>	<p>Please indicate whether the prescription is to be filled:</p> <p><input type="checkbox"/> through the US Family Health Plan Mail Order Pharmacy OR</p> <p><input type="checkbox"/> at a retail network pharmacy</p>
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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 Please explain why the patient cannot be treated with a formulary medication.

<p>1. Has the patient failed an adequate trial, been unable to tolerate, or have contraindications that preclude treatment with at least two formulary SSRIs? Please explain below.</p>	<input type="checkbox"/> Yes Please explain below, then sign and date	<input type="checkbox"/> No Please go to Question 2
Medication	Explanation - describe the therapeutic failure, intolerance, or contraindication (Note: an adequate trial is in general considered to be at least 6 weeks in duration.)	
Citalopram		
Fluoxetine		
Paroxetine immediate release		
Sertraline (Zoloft)		
<p>2. Has the patient previously responded to Lexapro, and changing to a formulary SSRI would incur unacceptable risk? (e.g., patient is currently stabilized on therapy with Lexapro and changing to a formulary SSRI would present a risk of destabilization.) Please explain below.</p>		

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

_____ Prescriber Signature	_____ Date
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