

# US Family Health Plan Pharmacy Program

## Aciphex, Dexilant/Kapidex, Prevacid, Protonix, and Zegerid Medical Necessity Form

This form applies to the US Family Health Plan Mail Order Pharmacy and the US Family Health Plan Retail Pharmacy programs. This form must be completed and signed by the prescriber.

- Proton pump inhibitors (PPIs) on the DoD Uniform Formulary include omeprazole and esomeprazole (Nexium), both of which are available at a \$3 cost share. Aciphex, Dexilant [formerly named Kapidex], Prevacid, Protonix, and Zegerid are non-formulary, but available to many beneficiaries at a \$22 cost share. Please note that step therapy/prior authorization requirements (PA) apply to all non-formulary PPIs. This form may NOT be used to meet step therapy/PA requirements.
- The purpose of this form is to provide information that will be used to determine if the use of a non-formulary PPI instead of either of the formulary PPIs is medically necessary. If a non-formulary PPI is determined to be medically necessary AND the non-Active duty beneficiary has met step therapy/PA requirements, it will be available at the \$9 formulary cost share rather than the \$22 non-formulary cost share.

<b>MAIL ORDER</b>	<b>If the prescription is to be filled through the USFHP Mail Order Pharmacy, check here</b> <input type="checkbox"/>	<b>RETAIL</b>	<b>If the prescription is to be filled at a retail pharmacy, check here</b> <input type="checkbox"/>
	<ul style="list-style-type: none"> <li>The completed form and the prescription may be <b>faxed to 1-617-562-5296</b> OR</li> <li>The patient may attach the completed form to the prescription and <b>mail it to: Attn: Pharmacy, 77 Warren Street, Brighton, MA 02135</b></li> </ul>		<ul style="list-style-type: none"> <li>The provider may <b>call: 1-877-880-7007</b></li> <li style="text-align: center; padding: 5px 0;">OR</li> <li>The completed form may be <b>faxed to 1-617-562-5296</b></li> </ul>

**Step 1** Please complete patient and physician information (Please Print)

<b>1</b>	Patient Name: _____		Physician Name: _____
	Address: _____		Address: _____
	Sponsor ID: _____		Phone #: _____
	Date of Birth: _____		Secure Fax: _____

**Step 1. Please indicate which medication is being prescribed:**

- 2**
- |  |  |
|--|--|
| <input type="checkbox"/> Aciphex (rabeprazole)                               | <input type="checkbox"/> Protonix (pantoprazole)                 |
| <input type="checkbox"/> Dexilant [formerly named Kapidex] (dexlansoprazole) | <input type="checkbox"/> Zegerid (omeprazole/sodium bicarbonate) |
| <input type="checkbox"/> Prevacid (lansoprazole)                             |  |

**2. Please explain why the patient cannot be treated with a formulary alternative: omeprazole, esomeprazole (Nexium).**

Please indicate which of the reasons below (1-4) applies to each of the formulary PPIs listed in the table. You MUST circle a reason AND supply a specific written clinical explanation for EACH formulary alternative.

Formulary Alternative	Reason	Clinical Explanation
Omeprazole	1 2 3 4	
Esomeprazole (Nexium)	1 2 3 4	

1. Use of the formulary alternative is contraindicated (e.g., due to hypersensitivity).
2. The patient has experienced significant adverse effects from the formulary alternative.
3. Use of the formulary alternative has resulted in therapeutic failure.
4. Prevacid only – The patient is younger than 12 years of age.

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

**3**

Prescriber Signature	Date
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