

# US Family Health Plan Pharmacy Program Medical Necessity Form for Short-Acting Beta Agonists (SABA's)

This form applies to the USFHP Mail Order Pharmacy and the USFHP Retail Pharmacy Program and may be found on the USFHP Pharmacy website at [www.USFamilyHealth.org](http://www.USFamilyHealth.org). The form must be completed and signed by the prescriber.

- Albuterol inhalation solution (generics, AccuNeb) and inhaler (ProAir HFA, Proventil HFA, Ventolin HFA) and levalbuterol inhalation solution and inhaler (Xopenex inhalation solution, Xopenex HFA) are the Short-Acting Beta Agonists (SABAs) on the DoD Uniform Formulary. Metaproterenol inhalation solution and Maxair Autohaler (pirbuterol) 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 nonformulary 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.

<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</b> it to: <b>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>OR</li> <li>The completed form may be <b>faxed to 1-617-562-5296</b></li> </ul>

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 #: \_\_\_\_\_  
 Secure Fax: \_\_\_\_\_

**Step 1. Please indicate which short-acting beta agonist 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
Albuterol inhalation solution (generics, AccuNeb) and inhaler (ProAir HFA, Proventil HFA, Ventolin HFA)	1 2 3	
Levalbuterol inhalation solution and inhaler (Xopenex)	1 2 3	

- Use of the formulary medication is contraindicated (e.g., due to hypersensitivity).
- The patient has experienced or is likely to experience significant adverse effects from the formulary medication.
- The patient previously responded to the non-formulary medication and changing to a formulary medication would incur unacceptable risk (e.g., risk of destabilization, abrupt worsening of symptoms).

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

**3** \_\_\_\_\_ Date \_\_\_\_\_

Prescriber Signature