

US Family Health Plan Medical Necessity Form for Targeted Immunomodulatory Biologics (TIBs) – Cimzia, Enbrel, Kineret, Simponi

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan pharmacy program (USFHP).

- Formulary medications in this drug class (the Targeted Immunomodulatory Biologics) include Humira and Amevive. Cimzia, Enbrel, Kineret, and Simponi are non-formulary, but available to most beneficiaries at a \$22 cost share. **NOTE:** Remicade, Orencia, and Rituxan, which are given intravenously, are covered by US Family Health Plan under the medical benefit.
- You do NOT need to complete this form in order for non-active duty beneficiaries to obtain the non-formulary medication 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 the 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.
- Note: Medications in this class require prior authorization before they will be covered by US Family Health Plan for a patient newly starting on treatment. This form does NOT fulfill prior authorization requirements. Please see: http://www.usfamilyhealth.org/f-downloadable_forms.html

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

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

- Please indicate which medication is being requested: _____
- Please explain why the patient cannot be treated with Humira (adalimumab). Please indicate which of the reasons (1-4) applies. You **MUST** circle a reason AND supply a specific written clinical explanation.

Formulary Medication	Reason	Clinical Explanation
Humira (adalimumab)	1 2 3 4	

- Use of Humira is contraindicated (e.g., due to hypersensitivity).
- The patient has experienced or is likely to experience significant adverse effects from Humira.
- Use of Humira has resulted or is likely to result in therapeutic failure.
- The patient previously responded to a non-formulary agent and changing to Humira would incur unacceptable risk.

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

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Prescriber Signature

Date