

US Family Health Plan Pharmacy Program Medical Necessity Form for Triptan Agents (Amerge, Axert, and Frova)

This form applies to the US Family Health Plan Mail Order Pharmacy and the US Family Health Plan Retail Pharmacy Program and may be found on the US Family Health Plan Pharmacy website at www.USFamilyHealth.org. The form must be completed and signed by the prescriber.

- Triptan agents on the DoD Uniform Formulary include: Imitrex (sumatriptan), Maxalt (rizatriptan), Relpax (eletriptan), Treximet (sumatriptan/naproxen), and Zomig (zolmitriptan).
- **Amerge (naratriptan), Axert (almotriptan), and Frova (frovatriptan) 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.

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 <li style="text-align: center;">OR • The completed form may be faxed to 1-617-562-5296

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 #: _____
	Date of Birth: _____	Secure Fax: _____

Step 2 Please explain why the patient cannot be treated with a formulary alternative. You MUST circle a reason AND supply a specific written clinical explanation

Formulary Alternative	Reason	Clinical Explanation
Imitrex (sumatriptan)	1 2 3 4	
Maxalt (rizatriptan)	1 2 3 4	
Relpax (eletriptan)	1 2 3 4	
Treximet (sumatriptan/naproxen)	1 2 3 4	
Zomig (zolmitriptan)	1 2 3 4	

Acceptable clinical reasons for not using a formulary alternative are:

1. Use of the formulary alternative is contraindicated (e.g., due to hypersensitivity to a dye or other inert ingredient).
2. The patient has experienced significant adverse effects from the formulary alternative.
3. Use of the formulary alternative has resulted in therapeutic failure.
4. The patient previously responded to either of the non-formulary agents, Amerge, Axert, or Frova, and changing to a formulary alternative would incur an unacceptable clinical risk to the patient.

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