

# TRICARE Pharmacy Program Medical Necessity Form for Ophthalmic Glaucoma Agents, (Azopt, Betimol, Istalol, and Travatan/Travatan Z)



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This form applies to the TRICARE Pharmacy Program (TPharm). The medical necessity criteria outlined on this form also apply at Military Treatment Facilities (MTFs). The form must be completed and signed by the prescriber.

- Topical glaucoma agents on the DoD Uniform Formulary include most ophthalmic glaucoma agents available in the U.S. **Azopt, Betimol, Istalol, and Travatan/Travatan Z are non-formulary, but available to most beneficiaries at the non-formulary 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 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 formulary cost share.
- TRICARE will not cover a non-formulary medication for Active duty service members unless it is determined to be medically necessary *instead of a formulary medication*. If a non-formulary medication is determined to be medically necessary, it will be available to Active duty service members at no cost share.

<b>MAIL ORDER and RETAIL</b>	<ul style="list-style-type: none"> <li>• The provider may <b>call: 1-866-684-4488</b> or the completed form may be <b>faxed to: 1-866-684-4477</b></li> <li>• The patient may attach the completed form to the prescription and <b>mail it to: Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954</b> or <b>email</b> the form only to: <b>TpharmPA@express-scripts.com</b></li> </ul>	<b>MTF</b>	<ul style="list-style-type: none"> <li>• Non-formulary medications are available at MTFs only if <b>both</b> of the following are met:                             <ul style="list-style-type: none"> <li>○ The prescription is written by a military provider or, at the discretion of the MTF, a civilian provider to whom the patient was referred by the MTF.</li> <li>○ The non-formulary medication is determined to be medically necessary.</li> </ul> </li> <li>• Please contact your local MTF for more information. There are no cost shares at MTFs.</li> </ul>
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**Step 1** Please complete patient and physician information (Please Print)

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID # _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

**Step 2** 1. Please indicate which medication is being prescribed:

<input type="checkbox"/> Azopt (brinzolamide)	Please go to Question 2
<input type="checkbox"/> Betimol (timolol hemihydrate)	Please go to Question 3 on Page 2
<input type="checkbox"/> Istalol (timolol maleate)	
<input type="checkbox"/> Travatan (travoprost BAK preservative)	Please go to Question 4 on Page 2
<input type="checkbox"/> Travatan Z (travoprost Sofzia preservative)	

**Azopt (brinzolamide)**

2. Please explain why the patient cannot be treated with the formulary agent dorzolamide (Trusopt), which is also a carbonic anhydrase inhibitor. A specific explanation is required. You **MUST** circle a reason **AND** supply a specific written clinical explanation.

Formulary Alternative	Reason	Clinical Explanation
dorzolamide (Trusopt)	1 2 3	

1. The formulary agent is contraindicated (e.g., due to hypersensitivity to the agent or an inert ingredient).
2. The patient has experienced significant adverse effects with the formulary agent.
3. An adequate trial of the formulary agent resulted in therapeutic failure.

**Questions for Betimol, Istalol, and Travatan/Travatan Z are on Page 2. For all products, please sign and date at the bottom of Page 2.**

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**Step 2 Betimol (timolol hemihydrate), Istalol (timolol maleate)**

3. Please indicate which of the reasons below (1-3) applies to each of the formulary beta blockers listed in the table. You **MUST** circle a reason **AND** supply a specific written clinical explanation for **EACH** formulary alternative. Please note that timolol maleate solution (Timoptic, generics) and gel-forming solution (Timoptic XE, generics) are on the Uniform Formulary.

Formulary Alternative	Reason	Clinical Explanation
carteolol (Ocupress)	1 2 3	
levobunolol (Betagan)	1 2 3	
metipranolol (Optipranolol)	1 2 3	
timolol maleate (Timoptic/Timoptic XE)	1 2 3	

1. The formulary agent is contraindicated (e.g., due to hypersensitivity to the agent or an inert ingredient).
2. The patient has experienced significant adverse effects with the formulary agent.
3. An adequate trial of the formulary agent resulted in therapeutic failure.

**Travatan (travoprost BAK preservative), Travatan Z (travoprost Sofzia preservative)**

4. Please indicate which of the reasons below (1-3) applies to each of the formulary prostaglandin analogs 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
bimatoprost (Lumigan)	1 2 3	
latanoprost (Xalatan)	1 2 3	

1. The formulary agent is contraindicated (e.g., due to hypersensitivity to the agent or an inert ingredient).
2. The patient has experienced significant adverse effects with the formulary agent.
3. An adequate trial of the formulary agent resulted in therapeutic failure.

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

**3**

\_\_\_\_\_ Prescriber Signature

\_\_\_\_\_ Date