

TRICARE Pharmacy Program Medical Necessity Form for Ketek (telithromycin) and Zmax (azithromycin sustained release suspension)



5542

THIS FORM MUST BE COMPLETED AND SIGNED BY THE PRESCRIBER. This form applies to the TRICARE Pharmacy (TPharm) program. **Formulary macrolide/ketolide antibiotics** on the DoD Uniform Formulary include: **all azithromycin products except for Zmax, clarithromycin, and erythromycin.** Ketek (telithromycin) and Zmax (azithromycin sustained release suspension) 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.
- Active duty service members may not fill prescriptions for a non-formulary medication unless it is determined to be medically necessary. There is no cost share for active duty service members at any DoD pharmacy point of service.

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

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

Step 2 Ketek: Please explain why the patient cannot be treated with any of the formulary alternatives:

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

Formulary Alternative	Reason	Detailed Clinical Explanation
Azithromycin (except Zmax)	1 2 3 4	
Clarithromycin	1 2 3 4	
Erythromycin	1 2 3 4	

Acceptable clinical reasons for not using a formulary alternative are:

1. The formulary alternative is contraindicated (e.g. due to a hypersensitivity reaction).
2. The patient has experienced significant adverse effects with the formulary alternative.
3. Use of the formulary alternative has resulted in therapeutic failure or is likely to result in therapeutic failure (e.g., due to lack of activity against a particular organism) AND Ketek therapy is appropriate.
4. The patient cannot be treated with a formulary alternative due to recent history of documented multi-drug resistant *S. pneumoniae* AND use of other formulary antibiotics (e.g., fluoroquinolones, high dose aminopenicillins) is not appropriate.

Zmax: Please explain why the patient cannot be treated with a formulary azithromycin product (250 or 500mg tablets or immediate release suspension):

Use of ALL other azithromycin products (250 or 500mg tablets or immediate release suspension) is contraindicated (e.g., hypersensitivity to a dye or other inert ingredient), and treatment with Zmax sustained release suspension is not contraindicated.
 Please provide a clinical explanation in the space below:

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

_____	_____
Prescriber Signature	Date