

TRICARE Pharmacy Program Medical Necessity Form for Ambien CR, Edluar, Rozerem, and Sonata



5546

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.

- Newer sedative hypnotic agents on the DoD Uniform Formulary include zolpidem immediate release (Ambien) and eszopiclone (Lunesta). **Zolpidem extended release (Ambien CR), zolpidem sublingual tablets (Edluar), ramelteon (Rozerem), and zaleplon (Sonata) are non-formulary, but available to most beneficiaries at the non-formulary cost share.** Please note that prior authorization (PA) requirements apply to all drugs in this class except zolpidem immediate release (Ambien). PA forms are available on the TRICARE Pharmacy website at: http://pec.ha.osd.mil/forms_criteria.php. This Medical Necessity form may **NOT** be used to meet PA requirements.
- 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 either of the formulary medications is medically necessary. If a non-formulary medication is determined to be medically necessary AND the non-active duty beneficiary has met PA requirements, it will be available at the formulary cost share rather than the non-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 AND the patient has met PA requirements. If a non-formulary medication is determined to be medically necessary AND the Active duty service member has met PA requirements, it will be available at no cost share.

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	<p>1. Non-formulary medications are available at MTFs only if both of the following are met:</p> <p style="margin-left: 20px;">a. 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.</p> <p style="margin-left: 20px;">b. The non-formulary medication is determined to be medically necessary.</p> <p>2. Please contact your local MTF for more information. There are no cost shares at MTFs.</p>
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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 1. Please indicate which medication is being prescribed:

- 2
- Ramelteon (Rozerem)
 - Zaleplon (Sonata)
 - Zolpidem extended-release (Ambien CR)
 - Zolpidem sublingual tablets (Edluar)

2. Please explain why the patient cannot be treated with either of the formulary medications:

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

Formulary Medication	Reason	Clinical Explanation
Zolpidem immediate release (Ambien)	1 2 3 4 5	
Eszopiclone (Lunesta)	1 2 3 4 5	

Acceptable clinical reasons for not using a formulary medication are:

1. Use of the formulary medication is contraindicated (e.g., due to hypersensitivity).
2. The patient has experienced or is likely to experience significant adverse effects from the formulary medication.
3. Use of the formulary medication has resulted in therapeutic failure.
4. **(Rozerem only)** Rozerem, which is a non-controlled drug with a mechanism of action different from other newer sedative hypnotics, is the most clinically suitable choice for this patient due to its apparent lack of abuse potential.
5. **(Edluar only)** The patient is unable to swallow or has difficulty swallowing.

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
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