

TRICARE Pharmacy Program Medical Necessity Form for Overactive Bladder (OAB) Medications



5547

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.

- **Detrol LA (tolterodine sustained-release), Ditropan XL (oxybutynin sustained-release), Enablex (darifenacin), Oxytrol (oxybutynin patch), Vesicare (solifenacin), and oxybutynin immediate-release** are the formulary OAB medications on the DoD Uniform Formulary.
- **Detrol (tolterodine immediate-release), Gelnique (oxybutynin topical gel), Sanctura (trospium), and Toviaz (fesoterodine) 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: _____
Sponsor ID#: _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

Step 2 1. Please indicate which medication is being requested:

2. Please explain why the patient cannot be treated with any of the formulary medications:
Please indicate which of the reasons below (1-3) 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
Darifenacin (Enablex)	1 2 3	
Oxybutynin patch (Oxytrol)	1 2 3	
Oxybutynin sustained-release (Ditropan XL)	1 2 3	
Solifenacin (Vesicare)	1 2 3	
Tolterodine sustained-release (Detrol LA)	1 2 3	

The criteria do not include oxybutynin immediate-release as a formulary alternative due to its multiple daily dosing requirement and greater incidence of adverse effects (e.g., dry mouth) when used chronically, compared to longer-acting OAB medications. Patients are not required to have tried oxybutynin immediate-release.

- Acceptable clinical reasons for not using a formulary medication are:**
1. The formulary medication is contraindicated (e.g., due to a hypersensitivity reaction).
 2. The patient has experienced significant adverse effects with the formulary medication that are not expected to occur with the non-formulary OAB medication.
 3. **Detrol, Sanctura, or Toviaz request only** - An adequate trial of the formulary medication resulted in therapeutic failure.

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

_____	_____
Prescriber Signature	Date