

TRICARE Pharmacy Program Medical Necessity Form for

Long-Acting Beta Agonists (LABA's)



5598

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.

- Long-Acting Beta Agonists (LABAs) on the DoD Uniform Formulary include: salmeterol DPI (Serevent Diskus), formoterol DPI (Foradil Aerolizer) and arformoterol inhalation solution (Brovana). **Formoterol inhalation solution (Perforomist) is non-formulary, but available to most beneficiaries 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 LABA *instead of a formulary LABA* is medically necessary. If a non-formulary LABA 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 LABA for Active duty service members unless it is determined to be medically necessary *instead of a formulary LABA*, in which case it will be available to Active duty service members 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	<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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There is no expiration date for approved medical necessity determinations.

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 explain why the patient cannot be treated with a formulary medication: 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 specific written clinical explanation for EACH formulary medication.**

Formulary Medication	Reason	Clinical Explanation
Salmeterol DPI (Serevent Diskus)	1 2 3	
Formoterol DPI (Foradil Aerolizer)	1 2 3	
Arformoterol inhalation solution (Brovana)	1 2 3	

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. The patient previously responded to formoterol inhalation solution (Perforomist) and changing to any formulary medication would incur an unacceptable clinical risk to the patient (e.g., risk of destabilization, abrupt worsening of symptoms).

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

Prescriber Signature	Date