

# TRICARE Pharmacy Program Medical Necessity Form for Targeted Immunomodulatory Biologics (TIBs) – Cimzia, Enbrel, Kineret, Simponi



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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.

- Formulary medications in this drug class (the Targeted Immunomodulatory Biologics) include Humira and Amevive. **Cimzia, Enbrel, Kineret, and Simponi are non-formulary, but available to most beneficiaries at the non-formulary cost share.** NOTE: Remicade, Orencia, and Rituxan, which are given intravenously, are covered by TRICARE under the medical benefit.
- You do **NOT** need to complete this form in order for non-active duty beneficiaries to obtain the non-formulary medication 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 the 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.
- Note: Medications in this class require prior authorization before they will be covered by TRICARE for a patient newly starting on treatment. This form does NOT fulfill prior authorization requirements. Please see: [http://pec.ha.osd.mil/forms\\_criteria.php](http://pec.ha.osd.mil/forms_criteria.php) for more information.

<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 requested: \_\_\_\_\_
2. Please explain why the patient cannot be treated with Humira (adalimumab).  
Please indicate which of the reasons (1-4) applies. You **MUST** circle a reason **AND** supply a specific written clinical explanation.

Formulary Medication	Reason	Clinical Explanation
Humira (adalimumab)	1 2 3 4	

1. Use of Humira is contraindicated (e.g., due to hypersensitivity).
2. The patient has experienced or is likely to experience significant adverse effects from Humira.
3. Use of Humira has resulted or is likely to result in therapeutic failure.
4. The patient previously responded to a non-formulary agent and changing to Humira would incur unacceptable risk.

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

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