TRICARE Pharmacy Program Medical Necessity Form for Daytrana, Focalin, Focalin XR

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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 for Attention-Deficit / Hyperactivity Disorder (ADHD) include Adderall immediate-release and Adderall XR and generics, Concerta and generics, Metadate CD, Ritalin LA, Strattera, immediate/sustained release methylphenidate, dextroamphetamine, and methamphetamine.** Daytrana (methylphenidate patch), Focalin (immediate release dexmethylphenidate), Focalin XR (extended release dexmethylphenidate), and Vyvanse (lisdexamfetamine) are non-formulary, but available to most beneficiaries at the non-formulary cost share. NOTE: This form applies to Daytrana, Focalin, and Focalin XR. A separate form applies to Vyvanse.
- You do NOT need to complete this form in order for non-active duty beneficiaries (spouses, dependents, and retirees) to obtain Daytrana, Focalin, or Focalin XR 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 Daytrana, Focalin, or Focalin XR 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.

MAIL ORDER and RETAIL	• 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	• Non-formulary medications are available at MTFs only if both of the following are met: o 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. o 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.

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

Non-formulary medication requested: ☐ Dexmethylphenidate products (Focalin, Focalin XR) ☐ Methylphenidate patch (Daytrana)

Please explain why the patient cannot be treated with the formulary medications. Circle a reason code if applicable. You MUST supply a specific written clinical explanation as to why each of the formulary medications would be unacceptable.

Formulary Alternative	Reason	Clinical Explanation
Extended release methylphenidate (e.g., Concerta, Metadate CD, Ritalin LA)	1 2 3 4	
Extended release mixed amphetamine salts (Adderall XR)	1 2 3 4	

Note: The formulary alternatives listed above only include the extended release stimulant products. In most cases, Focalin (dexmethylphenidate immediate release) would be used for dose titration or to supplement the use of Focalin XR, not as a sole therapy; therefore, medical necessity review is based on the extended release stimulant products. Approved medical necessity determinations for dexmethylphenidate products will apply to both Focalin and Focalin XR.

Acceptable clinical reasons for not using a formulary alternative are:

1. Use of the formulary alternative is contraindicated (e.g., due to hypersensitivity).
2. The patient has experienced or is likely to experience significant adverse effects from the formulary alternative.
3. Use of the formulary alternative has resulted in therapeutic failure.
4. **Daytrana patch only** – the patient is unable to take oral medications.

Step 3

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

_____ _____

Prescriber Signature Date

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