

# TRICARE Pharmacy Program Medical Necessity Form for Levemir FlexPen (insulin detemir pen device)



5621

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.

- The long-acting basal insulin analogues for the treatment of diabetes mellitus on the DoD Uniform Formulary include Levemir vial (insulin detemir), and Lantus (insulin glargine) vial and Lantus SoloStar prefilled pen device. **Levemir FlexPen (insulin detemir prefilled pen device) is non-formulary, but available to most beneficiaries at the non-formulary cost share. The Levemir vial is formulary.**
- The purpose of this form is to provide information that will be used to determine if the use of the non-formulary Levemir FlexPen device instead of the formulary Levemir vial, or Lantus vial or SoloStar pen device is medically necessary. If the non-formulary Levemir FlexPen device is determined to be medically necessary, non-Active duty beneficiaries may obtain it at the formulary cost share.
- TRICARE will not cover the Levemir FlexPen device for Active duty service members unless it is determined to be medically necessary instead of a formulary medication or product, in which case it will be available to Active duty service members at no cost share.

<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)

<b>1</b>	Patient Name: _____	Physician Name: _____
	Address: _____	Address: _____
	Sponsor ID #: _____	Phone #: _____
	Date of birth: _____	Secure Fax #: _____

**Step 2** Please explain why the patient cannot be treated with a formulary medication or product: Please indicate which of the reasons below (1-4) apply for the formulary medications listed in the table. You **MUST** circle a reason **AND** supply a specific written clinical explanation for each formulary medication.

Formulary Medications	Reason	Clinical
Lantus vial (insulin glargine vial)	1 2 3 4	
Lantus SoloStar (insulin glargine prefilled pen device)	1 2 3 4	
Levemir vial (insulin detemir vial)	4	

1. Use of the formulary medication is contraindicated (e.g., due to hypersensitivity).
2. The patient has experienced significant adverse effects from the formulary medication.
3. Use of the formulary medication has resulted in therapeutic failure.
4. The patient previously responded to use of the Levemir FlexPen device and changing to a formulary medication or product would incur an unacceptable clinical risk because the patient requires twice daily dosing and has manual dexterity or visual limitations.

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

**Step 3**

Prescriber Signature	Date
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