

TRICARE Pharmacy Program Medical Necessity Form for Newer Antihistamine Agents (Clarinet, Clarinet D and Xyzal)



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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.

- Newer antihistamines on the DoD Uniform Formulary include fexofenadine (generic Allegra), fexofenadine/pseudoephedrine (Allegra D), and Semprex D. **Clarinet, Clarinet D, and Xyzal are 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 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*, 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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Step 1 Please complete patient and physician information (Please Print)

1	Patient Name: _____	Physician Name: _____
	Address: _____	Address: _____
	Sponsor ID #: _____	Phone #: _____
	Date of Birth: _____	Secure Fax #: _____

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

Clarinet (desloratadine) Clarinet D (desloratadine/pseudoephedrine) Xyzal (levocetirizine)

2. Please explain why the patient cannot be treated with a formulary alternative:

Please indicate which of the reasons below (1-3) applies to each of the formulary alternatives listed in the table. You **MUST** circle a reason **AND** supply a specific written clinical explanation for formulary alternatives.

Formulary Alternative	Reason	Clinical Explanation
Fexofenadine (generic Allegra) or Allegra D	1 2 3	
PSE = pseudoephedrine		

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 significant adverse effects from the formulary alternative.
3. Use of the formulary alternative has resulted in therapeutic failure.

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

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Prescriber Signature	Date