

TRICARE Pharmacy Program Medical Necessity Form for Self Monitoring Blood Glucose Systems Test Strips (SMBGSs)



5607

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.

- Self Monitoring Blood Glucose Systems Test Strips (SMBGSs) on the DoD Uniform Formulary include Accu-Chek Aviva, Ascensia Contour, FreeStyle Lite, Precision Xtra, and TRUEtest. **All other SMBGS test strip brands are non-formulary, but available to most beneficiaries at a \$22 cost share.**
- The purpose of this form is to provide information that will be used to determine if the use of a non-formulary SMGBS test strip *instead of a formulary SMGBS test strip* is medically necessary. If a non-formulary SMBGS test strip is determined to be medically necessary, non-Active duty beneficiaries may obtain it at the \$9 formulary cost share.

There is no expiration date for approved medical necessity determinations.

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.

Please complete patient and physician information (Please Print)

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

Step 2 1. Please indicate which glucose test strip is being requested:

2. Please explain why the patient cannot use a formulary alternative:

Please indicate which of the reasons below (1-4) apply for the formulary alternatives listed in the table. You **MUST** circle a reason **AND** supply a specific written clinical explanation for the formulary alternatives.

Formulary Alternatives	Reason	Clinical Explanation
Accu-Chek Aviva	1 2 3 4	
Ascensia Contour		
FreeStyle Lite		
Precision Xtra		
TRUEtest		

1. The patient reasonably would not be able to use a formulary blood glucose meter and strips appropriately or effectively instead of the requested blood glucose meter and formulary excluded strips.
2. The patient has a documented physical or mental health disability requiring a special monitor (e.g. visual impairment).
3. The patient is using the Medtronic Mini Med Paradigm insulin pump with the One Touch Ultra Link meter (One Touch Ultra test strips) or the patient is using the One Touch Ping insulin pump and One Touch Ping meter (One Touch Ultra test strips).
4. The patient is receiving peritoneal dialysis or the intravenous immune globulin (IVIG) preparation Octagam and the provider is concerned about the glucose dehydrogenase-pyrroloquinolinequinone interaction (GDH-PQQ) .

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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