

TRICARE Pharmacy Program Medical Necessity Form for Avandia, Avandamet, Avandaryl



5636

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.

- Actos (pioglitazone) and its fixed-dose combination products Actoplus Met, Actoplus Met XR, and Duetact, are formulary and available at the formulary cost share. **Avandia (rosiglitazone) and its fixed-dose combination products Avandamet and Avandaryl are non-formulary, but available to most beneficiaries at the nonformulary cost share.**
- You do NOT need to complete this form in order for non-Active duty beneficiaries (spouses, dependents, and retirees) to obtain non-formulary medications 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 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.
- Active duty service members may not fill prescriptions for a non-formulary medication unless it is determined to be medically necessary. There is no cost share for active duty service members at any DoD pharmacy point of service.

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):

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

Step 2 Non-formulary medication requested:

Avandia (rosiglitazone)
 Avandamet (rosiglitazone-metformin)
 Avandaryl (rosiglitazone-glimepiride)

Please explain why the patient cannot be treated with a formulary pioglitazone product (Actos product).

Please indicate which of the reasons below (1-2) applies to formulary medications. You must circle a reason AND supply a specific written clinical explanation.

Formulary Medications	Reason	Clinical Explanation
Actos (pioglitazone)	1 2	
Actoplus Met (pioglitazone-metformin)		
Actoplus Met XR (pioglitazone-metformin)		
Duetact (pioglitazone-glimepiride)		

Acceptable clinical reasons for not using the formulary medications:

1. Use of the formulary medications are contraindicated.
2. The patient previously responded to a non-formulary medication and changing to a formulary medication 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