US Family Health Plan
Medical Necessity Form for
Glucagon-Like Peptide-1 Receptor Agonists (GLP1RAs):
lixisenatide/insulin glargine (Soliqua)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan pharmacy program. US Family Health Plan is a TRICARE contractor for DoD.

MAIL ORDER		RETAIL	
	If the prescription is to be filled through the USFHP Mail Order Pharmacy, check here ☐ • The completed form may be **faxed** to **1-617-562-5296** OR • The patient may attach the completed form to the prescription and **mail** it to: **Attn: Pharmacy, 77 Warren St, Brighton, MA 02135**		**If the prescription is to be filled at a retail pharmacy, check here** ☐ • The provider may **call 1-877-880-7007** OR • The completed form may be **faxed** to **617-562-5296**

- **The formulary medications are Exenatide once weekly (Bydureon), Bydureon BCise, Trulicity and insulin glargine (Lantus).** Lixisenatide/insulin glargine (Soliqua) is non-formulary, but available to most beneficiaries at the non-formulary 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.

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

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 the formulary medications would be unacceptable.

Formulary Alternatives	Reason	Clinical Explanation
Exenatide once weekly (Bydureon), Bydureon BCise, Trulicity, and insulin glargine (Lantus)	1	

Acceptable clinical reasons for not using a formulary alternative are:

1. Use of formulary agents (GLP1RAs Bydureon/Bydureon BCise, Trulicity, AND insulin glargine) has resulted in therapeutic failure

Step 3

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

______________________ Prescriber Signature ______________ Date

[25 July 2018]