

US Family Health Plan Pharmacy Program Medical Necessity Form for Rapaflo (silodosin)

This form applies to the US Family Health Plan Pharmacy Program (USFHP). The form must be completed and signed by the prescriber.

- Doxazosin, terazosin, tamsulosin (Flomax) and Uroxatral (alfuzosin) are the formulary alpha blockers on the DoD Uniform Formulary for the treatment of symptoms of benign prostatic hypertrophy (BPH). Tamsulosin is available at a \$3 cost share and Uroxatral at a \$9 cost share. Rapaflo (silodosin) is non-formulary, but available to many beneficiaries at a \$22 cost share. Please note that step therapy/prior authorization (PA) requirements apply to patients newly starting on Rapaflo. PA forms are available on the US Family Health Plan Pharmacy website at http://www.usfamilyhealth.org/f-downloadable_forms.html. This form may NOT be used to meet step therapy/PA requirements.
- 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 \$22 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 AND a non-Active duty beneficiary has met step therapy/PA requirements, non-active duty beneficiaries may obtain it at the \$9 formulary cost share.

MAIL ORDER	If the prescription is to be filled through the USFHP Mail Order Pharmacy, check here <input type="checkbox"/>	RETAIL	If the prescription is to be filled at a retail pharmacy, check here <input type="checkbox"/>
	<ul style="list-style-type: none"> The completed form and the prescription 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 Street, Brighton, MA 02135 		<ul style="list-style-type: none"> The provider may call: 1-877-880-7007 <li style="text-align: center; padding: 5px 0;">OR The completed form may be faxed to 1-617-562-5296

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

Please explain why the patient cannot be treated with the formulary uroselective alpha blockers tamsulosin (Flomax) and Uroxatral (alfuzosin). NOTE: Doxazosin and terazosin are also on formulary at the generic (Tier 1 copay); however, patients are not required to try a non-selective alpha blocker before medical necessity will be approved for Rapaflo. **Please indicate which of the reasons below (1-4) applies. You MUST circle a reason AND supply a specific written clinical explanation.**

Formulary Medication	Reason	Clinical Explanation
Tamsulosin (Flomax)	1 2 3 4	
Uroxatral (alfuzosin)	1 2 3 4	

1. Use of the formulary medication is contraindicated (e.g., due to hypersensitivity or moderate to severe hepatic insufficiency).
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 requires a drug that can be crushed or sprinkled on food.

Step 3 I certify the above is correct and accurate to the best of my knowledge. Please Sign and Date:

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Prescriber Signature	Date
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