

US Family Health Plan BPH Alpha Blocker Prior Authorization Request Form Jalyn (dutasteride/tamsulosin) and Rapaflo (silodosin)

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 (USFHP)

PLEASE NOTE:

- Prior authorization for Jalyn or Rapaflo is **NOT** required for patients who are currently receiving a uroselective alpha blocker (Flomax [tamsulosin], Jalyn, Rapaflo, or Uroxatral), based on prescriptions filled during the last 6 months.
- No prior authorization is required for tamsulosin (generic for Flomax) which is available at a \$3 cost share, or for Uroxatral (alfuzosin) which is available at a \$9 cost share. Rapaflo (silodosin) is non-formulary and carries a \$22 cost share, and Jalyn is formulary and carries a \$9 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;">OR • The completed form may be faxed to 1-617-562-5296

Prior authorization criteria and a copy of this form are available at: http://www.usfamilyhealth.org/f-downloadable_forms.html

Drug for which Prior Authorization is requested Jalyn Rapaflo

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

1. Has the patient received a trial of tamsulosin or Uroxatral and had an inadequate response?	<input type="checkbox"/> Yes Please sign and date	<input type="checkbox"/> No Proceed to Question 2
2. Has the patient received a trial of tamsulosin or Uroxatral but was unable to tolerate it due to adverse effects?	<input type="checkbox"/> Yes Please sign and date	<input type="checkbox"/> No Proceed to Question 3
3. Is treatment with tamsulosin or Uroxatral contraindicated for this patient (e.g., due to hypersensitivity)?	<input type="checkbox"/> Yes Please sign and date	<input type="checkbox"/> No Proceed to Question 4
4. Is Rapaflo the medication being prescribed?	<input type="checkbox"/> Yes Proceed to Question 5	<input type="checkbox"/> No Coverage not approved
5. Does the patient require a drug that can be crushed or sprinkled on food? NOTE: Jalyn capsules should be swallowed whole and should NOT be crushed, chewed, or opened.	<input type="checkbox"/> Yes Please sign and date	<input type="checkbox"/> No Coverage not approved

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

3 Please sign and date

Prescriber Signature

Date