

# BPH Alpha Blocker Prior Authorization Request Form Jalyn (dutasteride/tamsulosin)



5647

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) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

**PLEASE NOTE:**

- Prior authorization for Jalyn is **NOT** required for patients who have received a prescription for either of the preferred alpha-1 blockers [A1Bs] tamsulosin (generic for Flomax) or alfuzosin (generic for Uroxatral) based on prescriptions filled during the last 6 months. The 5-alpha reductase inhibitors [5-ARIs] include the formulary agent finasteride (generic for Proscar) and the non-formulary agent dutasteride (Avodart).
- **NO** prior authorization is required for tamsulosin (generic for Flomax) or alfuzosin (generic for Uroxatral) which are available at the formulary cost share.

<b>MAIL ORDER and RETAIL</b>	<ul style="list-style-type: none"> <li>• The provider may call: <b>1-866-684-4488</b> or the completed form may be faxed to: <b>1-866-684-4477</b></li>   <li>• The patient may attach the completed form to the prescription and mail it to: <b>Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954</b> or email the form only to: <b>TpharmPA@express-scripts.com</b></li> </ul>
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Prior authorization criteria and a copy of this form are available at: [http://pec.ha.osd.mil/forms\\_criteria.php](http://pec.ha.osd.mil/forms_criteria.php).

**Step 1** Please complete patient and physician information (Please print):

<b>1</b>	Patient Name: _____	Physician Name: _____
	Address: _____	Address: _____
	_____	_____
	Sponsor ID #: _____	Phone #: _____
	Date of Birth: _____	Secure Fax #: _____

**Step 2** Please complete the clinical assessment:

<b>2</b>	1. Has the patient received a trial of tamsulosin or alfuzosin and had an inadequate response, <b>AND</b> requires therapy with both an alpha-1 blocker (A1B) and a 5-alpha reductase inhibitor (5-ARI)?	<input type="checkbox"/> Yes Please sign and date	<input type="checkbox"/> No Proceed to Question 2
	2. Has the patient received a trial of alfuzosin but was unable to tolerate it due to adverse effects but is expected to tolerate tamsulosin, <b>AND</b> requires therapy with both an A1B and a 5-ARI?	<input type="checkbox"/> Yes Please sign and date	<input type="checkbox"/> No Proceed to Question 3
	3. Is treatment with alfuzosin contraindicated for this patient (e.g., due to hypersensitivity) but tamsulosin is not contraindicated, <b>AND</b> the patient requires therapy with both an A1B and a 5-ARI?	<input type="checkbox"/> Yes Please sign and date	<input type="checkbox"/> No Proceed to Question 4
	4. Does the patient require therapy with both an A1B and a 5-ARI, <b>AND</b> requires a fixed-dose combination due to, for example, swallowing difficulties?	<input type="checkbox"/> Yes Please sign and date	<input type="checkbox"/> No Coverage not approved

**Step 3** I certify the above is true to the best of my knowledge.

Please sign and date:

\_\_\_\_\_  
 Prescriber Signature \_\_\_\_\_ Date