

BPH Alpha Blocker Prior Authorization Request Form Rapaflo (silodosin)



5646

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 Rapaflo is **NOT** required for patients who have received a prescription for either of the preferred agents tamsulosin (generic for Flomax) or alfuzosin (generic for Uroxatral) based on prescriptions filled during the last 6 months.
- **NO** prior authorization is required for tamsulosin (generic for Flomax) or alfuzosin (generic for Uroxatral) which are available at the formulary cost share. Rapaflo (silodosin) is non-formulary and carries a non-formulary cost share.

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
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Prior authorization criteria and a copy of this form are available at: http://pec.ha.osd.mil/forms_criteria.php.

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 complete the clinical assessment:

2	1. Has the patient received a trial of tamsulosin (Flomax) or alfuzosin (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 (Flomax) or alfuzosin (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 both tamsulosin (Flomax) and alfuzosin (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. Does the patient require a drug that can be crushed or sprinkled on food?	<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.

3 Please sign and date:

_____ Prescriber Signature	_____ Date
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