Prior Authorization Request Form for
dutasteride-tamsulosin (Jalyn)

JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

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 complete the clinical assessment:**

Question	Yes	No
1. Does the patient require therapy with both an alpha-1 receptor blocker and a 5-alpha reductase inhibitor?	☐ Yes Proceed to Question 2	☐ No Coverage not approved
2. Is the use of finasteride contraindicated in this patient (e.g. hypersensitivity)?	☐ Yes Sign and date below	☐ No Proceed to Question 3
3. Has the patient tried finasteride and was unable to tolerate it due to adverse effects?	☐ Yes Sign and date below	☐ No Proceed to Question 4
4. Does the patient require a fixed-dose combination due to, for example, swallowing difficulties?	☐ Yes Sign and date below	☐ 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

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For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: