

# US Family Health Plan Pharmacy Program

## Cialis (Tadalafil) and Viagra (Sildenafil) Medical Necessity Form

This form applies to the US Family Health Plan Mail Order Pharmacy and the US Family Health Plan Retail Pharmacy programs. This form must be completed and signed by the prescriber.

- Levitra is on the DoD Uniform Formulary at a \$9 cost share. Cialis and Viagra are non-formulary, but available to most beneficiaries at a \$22 cost share.
- You do NOT need to complete this form in order for non-active duty beneficiaries (spouses, dependents, and retirees) to obtain Cialis or Viagra 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 Cialis or Viagra instead of Levitra is medically necessary. If the use of Cialis or Viagra is determined to be medically necessary, non-active duty beneficiaries may obtain Cialis or Viagra at the \$9 formulary cost share.
- This form does NOT fulfill prior authorization requirements. Please see: [http://www.usfamilyhealth.org/f-downloadable\\_forms.html](http://www.usfamilyhealth.org/f-downloadable_forms.html) for more information. Quantity limits apply to all patients.

<b>MAIL ORDER</b>	<b>If the prescription is to be filled through the USFHP Mail Order Pharmacy, check here <input type="checkbox"/></b>	<b>RETAIL</b>	<b>If the prescription is to be filled at a retail pharmacy, check here <input type="checkbox"/></b>
	<ul style="list-style-type: none"> <li>The completed form and the prescription may be <b>faxed</b> to <b>1-617-562-5296</b> OR</li> <li>The patient may attach the completed form to the prescription and <b>mail</b> it to: <b>Attn: Pharmacy, 77 Warren Street, Brighton, MA 02135</b></li> </ul>		<ul style="list-style-type: none"> <li>The provider may <b>call: 1-877-880-7007</b></li> <li style="text-align: center;">OR</li> <li>The completed form may be <b>faxed to 1-617-562-5296</b></li> </ul>

**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:**

**2 The patient cannot be treated with Levitra for one of the following reasons:**

1. The patient had a hypersensitivity reaction to Levitra.	<input type="checkbox"/>
2. The patient has congenital or acquired QT prolongation.	<input type="checkbox"/>
3. The patient is receiving a class IA (e.g., quinidine, procainamide) or class III (e.g., amiodarone, sotalol) antiarrhythmic agent.	<input type="checkbox"/>
4. The patient is being treated for pulmonary arterial hypertension with either sildenafil or tadalafil.	<input type="checkbox"/>
5. The patient has experienced significant adverse effects from Levitra. A description of the adverse effect is REQUIRED:	<input type="checkbox"/>
6. For males with a diagnosis of erectile dysfunction, the patient has tried Levitra for at least 90 days, titrated to the maximum recommended dose, and experienced significant decrease in erectile function compared to previous therapy with Cialis or Viagra.	<input type="checkbox"/>
7. For males with a diagnosis of erectile dysfunction, the patient has tried Levitra for at least 90 days, titrated to the maximum recommended dose, and experienced no improvement in erectile function.	<input type="checkbox"/>
8. The patient is being treated for Raynaud's phenomenon or for the preservation/restoration of erectile function following prostatectomy and use of Levitra has resulted in therapeutic failure.	<input type="checkbox"/>

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

**3**

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Prescriber Signature Date