

US Family Health Plan Pharmacy Program

Cialis, Levitra, Staxyn, and Viagra Prior Authorization Request Form

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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.

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 This prior authorization has no expiration date.

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: _____

Please indicate which medication is being prescribed: **Cialis** **Levitra** **Staxyn** **Viagra**

Step 2 Please consider the following:

- Patients taking nitrates, either regularly or intermittently, should not receive PDE-5 inhibitors. Patients should be informed of the consequences should they initiate nitrate therapy while taking a PDE-5 inhibitor.
- Please see product labeling precautions for concurrent use with alpha blockers.

Step 3 1. Please indicate the patient's gender.

- 3** Female Please go to **Section 1** for **Female patients**
 Male Please go to **Section 2** for **Male patients on Page 2**

Section 1 – Female patients

1. Is the PDE-5 inhibitor being prescribed for the treatment of sexual dysfunction?	<input type="checkbox"/> Yes Coverage not approved	<input type="checkbox"/> No Proceed to Question 2
2. Is the PDE-5 inhibitor being prescribed for a diagnosis of pulmonary arterial hypertension (PAH)?	<input type="checkbox"/> Yes Coverage approved Please complete Question 4	<input type="checkbox"/> No Proceed to Question 3
3. Is the PDE-5 inhibitor being prescribed for a diagnosis of Raynaud's phenomenon?	<input type="checkbox"/> Yes Coverage approved Please complete Question 4	<input type="checkbox"/> No Coverage not approved
4. What is the dosing regimen?		

Please go to Step 4 on Page 3.

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Section 2 – Male patients

1. Is the requested medication Levitra?	<input type="checkbox"/> Yes Proceed to Question 2	<input type="checkbox"/> No STOP. Go to Section 3 on Page 3
2. Is the patient 18 years of age or older?	<input type="checkbox"/> Yes Proceed to Question 3	<input type="checkbox"/> No Proceed to Question 6
3. Is the patient 40 years of age or older?	<input type="checkbox"/> Yes Do not submit form. Prior authorization is not required for males 40 years or older.	<input type="checkbox"/> No Proceed to Question 4
4. Is the PDE-5 inhibitor being prescribed for the treatment of erectile dysfunction of organic origin? Organic impotence is considered a consequence of chronic medical conditions that result in impaired arterial blood flow or nerve damage, mixed organic/psychogenic causes, and necessary use of causative medications that cannot be reduced or discontinued. TRICARE regulations specifically exclude coverage of therapies for erectile dysfunction that is not of organic origin.	<input type="checkbox"/> Yes Coverage approved	<input type="checkbox"/> No Proceed to Question 5
5. Is the indication for the preservation or restoration of erectile function following prostatectomy?	<input type="checkbox"/> Yes Coverage approved To determine quantity requirements, please complete Question 8	<input type="checkbox"/> No Proceed to Question 6
6. Is the PDE-5 inhibitor being prescribed for a diagnosis of pulmonary arterial hypertension (PAH)?	<input type="checkbox"/> Yes Coverage approved To determine quantity requirements, please complete Question 8	<input type="checkbox"/> No Proceed to Question 7
7. Is the PDE-5 inhibitor being prescribed for a diagnosis of Raynaud's phenomenon?	<input type="checkbox"/> Yes Coverage approved To determine quantity requirements, please complete Question 8	<input type="checkbox"/> No Coverage not approved
8. What is the dosing regimen?		

Note: For treatment of erectile dysfunction of organic origin unrelated to therapy for preservation or restoration of erectile function following prostatectomy, coverage is limited to a collective quantity (sildenafil, vardenafil and/or tadalafil combined) of 6 tablets per 30 days or 18 tablets per 90 days.

Please go to Step 4 on Page 3.

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Section 3 – Male patients – Cialis, Staxyn, and Viagra

1. Has the patient received a trial of Levitra (vardenafil) 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 Levitra (vardenafil), 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 Levitra (vardenafil) 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 the requested medication being used for treatment of pulmonary arterial hypertension (PAH)?	<input type="checkbox"/> Yes Please sign and date Please complete Question 7	<input type="checkbox"/> No Proceed to Question 5
5. Is the requested medication being used for preservation/restoration of erectile function after prostatectomy?	<input type="checkbox"/> Yes Please sign and date Please complete Question 7	<input type="checkbox"/> No Proceed to Question 6
6. Is the requested medication being used for treatment of Raynaud's phenomenon?	<input type="checkbox"/> Yes Please sign and date Please complete Question 7	<input type="checkbox"/> No Coverage not approved
7. What is the dosing regimen?		

Please go to Step 4.

Step 4 I certify the above is correct and accurate to the best of my knowledge. Please sign and date:

Prescriber Signature

Date