



CONTAINS CONFIDENTIAL PATIENT INFORMATION

Adcirca® & Cialis® (tadalafil)

Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:

Prior Authorization of Benefits Center at (800) 601- 4829

1. PATIENT INFORMATION

2. PHYSICIAN INFORMATION

Form with fields for Patient Name, ID, DOB, Date of Rx, Phone, Email, Prescribing Physician, Address, Phone, Fax, Specialty, DEA, NPI, and Email Address.

3. MEDICATION

4. STRENGTH

5. DIRECTIONS

6. QUANTITY PER 30 DAYS

Form with checkboxes for Cialis and Adcirca, strength options (2.5mg, 5mg, 10mg, 20mg), directions, and quantity per 30 days.

**NOTE: QL – Specific to members EOC

7. DIAGNOSIS:

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

Erectile Dysfunction:

- Checkboxes for Yes/No for Patient is male, Patient has a documented diagnosis of erectile dysfunction, and Patient is on concurrent nitrate therapy.

Recommendations:

- 1. Physician should advise patients to stop use of all PDE-5 inhibitors and seek medical attention in the event of a sudden loss of vision in one or both eyes. Such an event may be a sign of non-arteritic anterior ischemic optic neuropathy (NAION), a cause of decreased vision, which can result in permanent loss of vision.
2. Physicians should discuss with patients the increased risk of NAION in individuals who have already experienced NAION in one eye, including whether such individuals could be adversely affected by use of vasodilators such as PDE-5 inhibitors.

Pulmonary Arterial Hypertension:

- Checkboxes for Yes/No for Patient has catheterization-proven diagnosis of Pulmonary Arterial Hypertension (PAH)*, Patient demonstrated an unfavorable acute hemodynamic response to vasodilators administered at cardiac catheterization, Patient has favorable response*, and has attempted treatment with oral vasodilators (calcium-channel antagonists) prior to the use of tadalafil, Is the patient on concurrent therapy with oral erectile dysfunction drugs, Is the patient on concurrent therapy with nitrates (nitric oxide is excluded), Does the patient have Retinitis Pigmentosa.



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Patient Name: _____ Patient ID #: _____

9. PHYSICIAN SIGNATURE

_____ Prescriber or Authorized Signature	_____ Date
<i>Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.</i>	
<small>Note: Payment is subject to member eligibility. Authorization does not guarantee payment.</small>	
IMPORTANT WARNING: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is STRICTLY PROHIBITED . If you have received this message by error, please notify us immediately at (800) 338-6180 and destroy the related message or return the document to us at 8407 Fallbrook Avenue AF13, West Hills, CA 91304. You, the recipient, are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure without appropriate patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in Federal and State law.	