



Prior Authorization Form

Erectile Dysfunction Agents

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: [] Viagra® (sildenafil) [] Levitra® (vardenafil) [] Cialis® (tadalafil)
(check one) [] MUSE® (alprostadil) [] Edex® (alprostadil) [] Caverject® (alprostadil)
[] Other (specify) _____

Note: Quantity limit of 8 units per month. Different quantity limits may apply to some groups.

Date: _____ Patient ID#: _____ DOB: _____
Patient Name: _____ Provider NPI: _____
Prescribing Physician: _____ Office Contact: _____
Office Fax #: _____ Office Phone: _____

ONLY COMPLETED REQUESTS WILL BE REVIEWED

1. DIAGNOSIS FOR DRUG REQUESTED:

[] Erectile Dysfunction [] Other (specify) _____

2. PATIENT HISTORY:

- a. Is the patient on Nitrates (in the past 6 months)? [] Yes [] No
b. Does the patient have diabetes? [] Yes [] No
d. History of prostate cancer treatment? [] Yes [] No
e. History of pelvic surgery and/or radiation therapy? [] Yes [] No
(specify): _____
f. History of spinal cord injury? [] Yes [] No
(specify): _____
g. History of neurologic disease? [] Yes [] No
(specify): _____
h. Has the patient tried and failed or has a contraindication/intolerance/allergy to a
testosterone containing product? [] Yes [] No
i. Has the patient had a radical prostatectomy in the past 6 months? [] Yes [] No

3. LABORATORY EVALUATION: (Required for patients less than 55 years old)

Serem testosterone level [] Free [] Total _____ Lab Normal Range _____ [] Not Done
Prolactin level Test result _____ Lab Normal Range _____ [] Not Done

Please add any other supporting medical information that may be useful in the decision-making process:

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

Internal use only Coverage effective date / /
Document # _____ Processor Initials _____ Date _____
M F Rx coverage Y N STANDARD - SELECT LOB _____
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