



Prior Authorization Form

Revatio® (Sildenafil)

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested:  Revatio®

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:

Pulmonary Hypertension

Other (specify) \_\_\_\_\_

2. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

N/A If none or not applicable to diagnosis, indicate "N/A."

Drug Name	Date	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. PATIENT HISTORY:

Is the patient currently taking nitrates?

Yes

No

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.

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M	F	Rx coverage	Y	N	STANDARD - SELECT	LOB _____
Previous Auth			Y	N	<b>Approved</b>	<b>Reviewer Initials</b> _____ <b>Date</b> _____