AmeriHealth

Prior Authorization Form

Erectile Dysfunction Agents

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: *(check one)*
☐ **Viagra®** (sildenafil) ☐ **Levitra®** (vardenafil) ☐ **Cialis®** (tadalafil)
☐ **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? *(specify):* _____	☐ Yes	☐ No
f. History of spinal cord injury? *(specify):* _____	☐ Yes	☐ No
g. History of neurologic disease? *(specify):* _____	☐ Yes	☐ No
h. Has the patient tried and failed or has a contraindication/intolerance/allergy to a testosterone containing product?	☐ 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_____

Previous Auth Y N **Approved** **Reviewer Initials**_____ Date_____