OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete forms will delay the authorization process.***

Drug Requested: **Cialis®** (tadalafil) ***(Non-Preferred)*** ***(MEDICAID)***

DRUG INFORMATION*: *Complete all information below or authorization process will be delayed.

Drug Form/Strength: _____

Dosing Administration: _____ **Length of Therapy**: _____

Diagnosis: _____ ***ICD Code, if applicable:*** _____

Length of Authorization: ***1 year***

CLINICAL CRITERIA*: *All boxes MUST be checked to ensure authorization will NOT be delayed.

- ❑ Prescriber is or in consultation with an Urologist ❑ Yes ❑ No
- ❑ Trial and failure of Alpha Blockers and Androgen Inhibitors for BPH ❑ Yes ❑ No
- ❑ Patient is ***NOT*** on the state's sex offenders list ❑ Yes ❑ No
- Is Cialis® being prescribed for lower urinary tract symptoms (LUTS) secondary to benign prostatic hypertrophy (BPH)? ❑ Yes ❑ No

  IF *YES*, has the patient tried **BOTH** an alpha-1 blocker for a ***minimum of 30 days***? ❑ Yes ❑ No

  ❑ alfuzosin ❑ tamsulosin

  AND

  a 5-alpha-reductase inhibitor for a ***minimum of 30 days***? ❑ finasteride ❑ Yes ❑ No

Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: 7/1/2018