# OPTIMA HEALTH COMMUNITY CARE
# AND
# OPTIMA FAMILY CARE
# (MEDICAID)

## 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)**

**DRUG INFORMATION**: Complete 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 below **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? ❑ Yes ❑ No

  ❑ alfuzosin **OR** ❑ tamsulosin

  **AND**

  a 5-alpha-reductase inhibitor? ❑ Yes ❑ No

  ❑ dutasteride **OR** ❑ finasteride

***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:** ~~6/28/2017; 8/28/2017; 8/17/2018;~~ **11/7/2018**