

**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.

- | | |
|--|--|
| <input type="checkbox"/> Prescriber is or in consultation with an Urologist | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Trial and failure of Alpha Blockers and Androgen Inhibitors for BPH | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Patient is <u>NOT</u> on the state's sex offenders list | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Is Cialis® being prescribed for lower urinary tract symptoms (LUTS) secondary to benign prostatic hypertrophy (BPH)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| IF <u>YES</u>, has the patient tried <u>BOTH</u> an alpha-1 blocker for a <u>minimum of 30 days</u> ? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> alfuzosin | <input type="checkbox"/> 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 #: _____