

OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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 information below. If incomplete, 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 or it can delay the authorization process.)

- | | | |
|--|--------------------------------------|--|
| <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 NOT 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 YES , has the patient tried BOTH an alpha-1 blocker for a minimum of 30 days ? | <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 ? | <input type="checkbox"/> finasteride | <input type="checkbox"/> Yes <input type="checkbox"/> 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: 6/28/2017; 8/28/2017