PRIOR AUTHORIZATION REQUEST: Erectile Dysfunction Agents

Please fax form and required documents to Amida Care: 1-646-786-0997

MEMBER INFORMATION	
Name:	Amida Care ID #:
Phone #:	Address:
PRESCRIBER INFORMATION	
Name/Title:	NPI:
Office Phone #:	Office Fax #:
Address:	
Contact Person:	

MEDICATION REQUEST
***** Please check specific medication requested*****

Medication	Strength	Dosage Form
☐ Adcirca (tadalafil)	20 mg **Generic**: 2.5 mg, 5 mg, 10 mg, 20 mg	Tablet, oral
☐ Cialis (tadalafil)	2.5 mg, 5 mg, 10 mg, 20 mg **Generic:** 2.5 mg, 5 mg, 10 mg, 20 mg	Tablet, oral
☐ Caverject (alprostadil)	Caverject Impulse Kit: 10 mcg, 20 mcg Caverject Reconstituted Solution: 20 mcg, 40 mcg	Intracavernous, injection
☐ Edex (alprostadil)	10 mcg, 20 mcg, 40 mcg	Intracavernous, injection
☐ Muse (alsprostadil)	125 mcg, 250 mcg, 500 mcg, 1000 mcg	Intraurethral, pellet
☐ Revatio (sildenafil citrate)	Tablet: 20 mg **Generic**: 20 mg, 25 mg, 50 mg, 100 mg Suspension, Brand and Generic: 10mg/mL IV solution, Brand and Generic: 10mg/12.5mL	Tablet, oral Suspension, oral Solution, IV
☐ Viagra (sildenafil citrate)	25 mg, 50 mg, 100 mg **Generic:** 20 mg, 25 mg, 50 mg, 100 mg	Tablet, oral
☐ Staxyn (vardenafil)	10 mg **Generic**: 10 mg	Tablet Disintegrating, oral
☐ Levitra (vardenafil HCl)	2.5 mg, 5 mg, 10 mg, 20 mg **Generic:** 2.5 mg, 5 mg, 10 mg, 20 mg	Tablet Film Coated, oral

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MEDICAL DIAGNOSIS/ASSOCIATED DRUG & DOSE
****Please check diagnosis and specify dose and frequency on blank lines****

- **Benign Prostatic Hyperplasia**: ____ every _____ QTY:_____
  - tadalafil 5 mg daily
- **Erectile Dysfunction**: _____every_____ QTY:_____
  - tadalafil 5-20 mg 30 min prior to intercourse or 2.5-5 mg daily
  - alprostadil 2.5 mcg intracavernously initially and titrate to produce erection
  - alprostadil 125-250 mcg intraurethrally initially with a maximum of 2 systems per day
  - sildenafil 25-100 mg 1 hr prior to intercourse
  - vardenafil film coated 5-20mg 1 hr prior to intercourse
  - vardenafil orally disintegrating 10 mg 1 hr prior to intercourse
- **Pulmonary Arterial Hypertension**: ____every_____ QTY:_____
  - tadalafil 40 mg daily
  - sildenafil 5-20 mg tid oral or 2.5-10 mg tid IV
- **Raynaud Phenomenon**: ____ every_____ QTY:_____
  - tadalafil 20 mg every other day
  - alprostadil 60 mcg IV over 3 hrs
  - sildenafil 50 mg bid
  - vardenafil 10 mg bid
- **Other[please specify]:**_____

CLINICAL INFORMATION & CRITERIA
[*Initial approval = 6 months. Renewal approval= 12 months*]

- Is this a/an ☐**initial request** ☐ **renewal request**
- Is patient taking concurrent nitrates, including patients with an emergency prescription for sublingual nitroglycerin? ☐ **yes** ☐ **no**
- Does patient have underlying cardiovascular disease that makes sexual activity undesirable? ☐ **yes** ☐ **no**
  - ☐ Hypotension <90/50 mm Hg
  - ☐ Uncontrolled hypertension >170/100 mm Hg
  - ☐ Unstable angina or angina during intercourse
  - ☐ Life threatening arrhythmia, stroke, or MI in the last 6 months
- Is the patient taking a Protease Inhibitor? ☐ **yes** ☐ **no**
  - ☐ max sildenafil 25 mg every 48 hours
  - ☐ max tadalafil: ED: 10 mg every 72 hours as needed or 2.5 mg daily, PAH: 20-40 mg daily after 1 week of ritonavir, BPH: 2.5 mg daily
  - ☐ max vardenafil 2.5mg every 72 hrs, vardenafil orally disintegrating not recommended
- Does the patient have renal dysfunction? ☐ **yes** ☐ **no**
  - ☐ CrCl >30 ☐ CrCl <30
- Does the patient have hepatic dysfunction? ☐ **yes** ☐ **no**

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☐ Child Pugh class A-B ☐ Child-Pugh class C

- Does provider agree to attach chart notes documenting the patient's condition?
  - ☐ Yes, chart notes are attached
  - ☐ No, my patient will not qualify for therapy coverage

Prior Treatment History	
Please list all prior treatments for the patient's condition:	Treatment Outcome (Adverse event / non-adherence / etc.)

- Is there any additional information the prescribing provider feels is important to this review?

Please call 646-757-7979, M-F, 9:00AM – 4:30PM with questions or additional information. You may also provide us with your contact information and the best time to reach you in the space at the top of this document.

_____ ____/____/_____

Prescriber or Authorized Signature Date