Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Cialis for BPH (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-844-242-0908**.
When conditions are met, we will authorize the coverage of Cialis for BPH (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Cialis 2.5mg (tadalafil) Cialis 5mg (tadalafil) Cialis 10mg, 20mg (tadalafil)

Other, please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

1. Has Aetna Better Health authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, then skip to question 3.]

2. Did the patient show improvement in symptoms (i.e., International Prostate Symptom Score (I-PSS) or AUA symptom score)? Y N

   [No further questions.]

3. Is this request for daily use of Cialis 2.5mg or 5mg tablets? Y N

   [If no, then no further questions.]

4. Does the patient have a diagnosis of benign prostatic hypertrophy (BPH)? Y N

   [If no, then no further questions.]

5. Has the patient experienced an inadequate treatment response, intolerance, or contraindication to alfuzosin or tamsulosin and one additional formulary alpha blocker agent (e.g., doxazosin, terazosin)? Y N

   Please list names of agents tried:

   _____

   [If no, then no further questions.]

6. Has the patient experienced an inadequate treatment response, intolerance, or contraindication to finasteride (for at least 6 months)? Y N

   [If no, then no further questions.]

7. Is the patient using any nitrate therapy (e.g., nitroglycerin, isosorbide dinitrate, isosorbide mononitrate or amyl nitrate) or Adempas? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date