Prior Authorization Form

CAREFIRST DC RISK

Cialis 2.5mg Step Therapy

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-855-582-2038** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Cialis 2.5mg Step Therapy.

Drug Name (select from list of drugs shown)

Cialis 2.5mg (tadalafil) Tadalafil 2.5mg

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: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is the requested drug being prescribed for daily use for symptomatic benign prostatic hyperplasia (BPH) with or without erectile dysfunction (ED) in a patient that is 18 years of age or older? Y N

[Note: Examples of signs and symptoms of BPH are incomplete emptying, weak stream, straining, urinary frequency, intermittency, or urgency.]

[If no, then skip to question 3.]

2. Has the patient experienced an inadequate treatment response, intolerance, or contraindication to an alpha-blocker and/or a 5 alpha-reductase inhibitor (5-ARI)? Y N

	[Note: Examples of trial drugs are alfuzosin, doxazosin, silodosin, tamsulosin, terazosin, dutasteride, finasteride 5 mg, Jalyn (dutasteride/tamsulosin).]
	[If yes, then skip to question 4.]
	[If no, then no further questions.]
3.	Is the requested drug being prescribed for erectile dysfunction in a patient that is 18 years of age or older? Y N
	[If no, then no further questions.]
4.	Does the patient require MORE than the plan allowance of 1 tablet per day? Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date