UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Cialis (tadalafil)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per Dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

For treatment of Pulmonary Arterial Hypertension refer to the Pulmonary Arterial Hypertension (PAH) pharmacy prior authorization form

Criteria for Approval: (*All* of the following criteria must be met):

1. Does the patient have a diagnosis of Benign Prostatic Hyperplasia (BPH) described in chart notes? ❑ **Yes** ❑ **No**
2. Has the provider verified that the medication is NOT being used for the treatment of Erectile Dysfunction? ❑ **Yes** ❑ **No**
3. Has the patient tried and failed or has a contraindication to at least one preferred alpha-1 antagonist or 5-alpha-reductase inhibitor? ❑ **Yes** ❑ **No**
   Medication and Dose: _____ Details of Failure: _____
4. **If request is for generic,** has the provider submitted appropriate clinical rationale for dispensing the generic medication instead of the preferred brand? ❑ **Yes** ❑ **No**
   Rationale: _____

Reauthorization Criteria:

1. Has the provider submitted an updated letter or medical necessity or updated chart notes demonstrating the patient has had a positive clinical response? ❑ **Yes** ❑ **No**

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Initial Authorization: Up to six (6) months
Reauthorization: Up to one (1) year

Note:

- This form ONLY applies to Cialis (tadalafil) specific NDCs used for Benign Prostatic Hyperplasia (BPH). Please use Pulmonary Arterial Hypertension Prior Authorization form for Alyq and Adcirca (tadalafil) NDCs.
- Per federal regulation, Medicaid does not reimburse for drugs used for the treatment of sexual dysfunction or erectile dysfunction. Cialis prescriptions for Benign Prostatic Hyperplasia should have that diagnosis included on the prescription and pharmacies should dispense only those Cialis (tadalafil) NDCs with the BPH indication.

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date