

UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Cialis (tadalafil)

Member and Medication Information	
<small>* indicates required field</small>	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
<input type="checkbox"/> Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information	
<small>* indicates required field</small>	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Medically Billed Information	
<small>* indicates required field for all medically billed products</small>	
*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

UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

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

For ADA accommodation or assistance completing this form, please call us at 801-538-6155.