



**MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM**

Tadalafil (BPH) - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Member Name:	Prescriber Name:
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: <input type="checkbox"/> Medicare Advantage	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):

☐ **REQUEST FOR EXPEDITED REVIEW:** By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the patient 18 years of age or older?

☐ Yes

☐ No

Q2. Will the patient take tadalafil in combination with either of the following: A) organic nitrates, or B) guanylate cyclase (GC) stimulators (e.g., riociguat)?

☐ Yes

☐ No

Q3. Is the patient being treated for erectile dysfunction (ED) in the absence of benign prostatic hyperplasia (BPH)?

☐ Yes

☐ No

Q4. Is there documentation showing a diagnosis of benign prostatic hyperplasia (BPH)?

☐ Yes

☐ No

Q5. Does the patient have a contraindication to both alpha blockers and 5-alpha-reductase inhibitors?

☐ Yes

☐ No



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Member Name:	Prescriber Name:
Q6. Has the patient had an inadequate response or inability to tolerate one alpha blocker? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. Has the patient had an inadequate response or inability to tolerate one 5-alpha-reductase inhibitor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Requested Duration: <input type="checkbox"/> 12 Months <input type="checkbox"/> Other:	
Q9. Additional Information:	

Prescriber Signature

Date

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