



This form is based on Express Scripts standard criteria and may not be applicable to all patients; certain plans and situations may require additional information beyond what is specifically requested.

Additional forms available: [www.express-scripts.com/pa](http://www.express-scripts.com/pa)

Fax completed form to **1-800-357-9577**  
If this an **URGENT** request, please call 1-800-417-8164

**Patient Information**

Patient First Name: \_\_\_\_\_  
Patient Last Name: \_\_\_\_\_  
Patient ID#: \_\_\_\_\_  
Patient DOB: \_\_\_\_\_  
Patient Phone #: \_\_\_\_\_

**Prescriber Information**

Prescriber Name: \_\_\_\_\_  
Prescriber DEA/NPI (required): \_\_\_\_\_  
Prescriber Phone #: \_\_\_\_\_  
Prescriber Fax #: \_\_\_\_\_  
Prescriber Address: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_

**Please indicate which drug and strength is being requested:**

- Cialis 2.5mg       Cialis 5mg       Cialis 10mg       Cialis 20mg

Directions for use (i.e. QD, BID, PRN & Qty): \_\_\_\_\_

**Please complete the clinical assessment:**

1. Does the patient have a diagnosis of erectile dysfunction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
2. Is the patient taking nitrates (for example: nitroglycerin, Isordil [isosorbide dinitrate], etc.)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3. If the diagnosis is <u>Raynaud disease (men or women)</u> , has the patient tried any of the following therapies? If yes, please indicate: <input type="checkbox"/> Alpha-adrenergic blockers (for example: Minipress, prazosin) <input type="checkbox"/> Angiotensin converting enzyme (ACE) inhibitors <input type="checkbox"/> Calcium channel blockers (for example: amlodipine, felodipine, isradipine, nifedipine) <input type="checkbox"/> Cozaar <input type="checkbox"/> Fluoxetine <input type="checkbox"/> Nitroglycerin <input type="checkbox"/> Vasodilator (for example: Flolan, Prostin, Tracleer) please indicate: _____ _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

<p>4. For <u>prophylaxis after nerve-sparing radical prostatectomy (early penile rehabilitation)</u>, has the patient had a nerve-sparing radical prostatectomy within the previous 12 months? If yes, is the requested medication prescribed by an urologist?</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<p>5. If the <u>diagnosis is benign prostatic hypertrophy (BPH)</u> has the patient tried an alpha-1-blocker [for example, doxazosin (Cardura XL), terazosin (Hytrin), tamsulosin (Flomax), alfuzosin extended-release (UroXatral) <b>OR</b> a 5-alpha-reductase inhibitor [for example, finasteride (Proscar), dutasteride (Avodart)]?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<p>6. If the <u>diagnosis is pulmonary hypertension (PAH) [men or women]</u>, is the patient unable to use Adcirca because the patient's dose is not available using Adcirca? <b>Note:</b> Adcirca is available in 20mg tablets.</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<p>7. If the <u>diagnosis is for women with antidepressant-associated sexual dysfunction</u>, is the patient currently taking a selective serotonin reuptake inhibitor (SSRI), a serotonin and norepinephrine reuptake inhibitor (SNRI) or Clomipramine? If yes, please list: _____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<p>8. If the <u>diagnosis is for high-altitude pulmonary edema (HAPE), treatment or prevention (for prevention must have a history of HAPE) [men or women] diagnosis only</u>, has the patient tried one other pharmacologic therapy (i.e., nifedipine, salmeterol, dexamethasone, acetazolamide, sildenafil)? If yes, please list therapies tried: _____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

**Are there any other comments, diagnoses, symptoms, and/or any other information the physician feels is important to this review?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Prescriber Signature: _____	Date: _____
Office Contact Name: _____ Phone Number: _____	

Based upon each patient's prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact our prior authorization team at the number listed on the top of this form.

Prior Authorization of Benefits is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for the patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

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