TRICARE **Quantity Limit** Override Request Form for **sildenafil (generic Viagra), tadalafil (generic Cialis) tablets**

6909

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

PLEASE NOTE: For Active Duty Service Members, even if coverage will NOT BE APPROVED per this form, it still must be initially submitted to the TPharm Contractor for review. Subsequent reconsideration is allowed at the appropriate Military Treatment Facility.

For initial review by the TPharm Contractor;

- The provider may **call**: **1-866-684-4488**
  or the completed form may be **faxed** to:
  1-866-684-4477

- The patient may attach the completed form
  to the prescription and **mail** it to: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954**
  or **email** the form only to:
  TPharmPA@express-scripts.com

Prior authorization expires in 365 days, except for prior authorization for Raynauld's disease/phenomenon, which does not expire.

Step 1

Please complete patient and information (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2

Please complete the clinical assessment:

1. What drug is being requested?	☐ Tadalafil - Proceed to question **2**	☐ Sildenafil citrate - Proceed to question **6**
2. What is the indication or diagnosis?	☐ Raynaud's disease/phenomenon - Proceed to question **3** ☐ Treatment of signs/symptoms of BPH (benign prostatic hyperplasia) - Proceed to question **4** ☐ Preservation or restoration of erectile function after prostatectomy - Proceed to question **5** ☐ Other indication or diagnosis - **STOP Coverage not approved**	
3. What is the dosing regimen? -- Please Note: Document the dose and directions.	_____ **Sign and date below**	
4. Which tablet strength of Cialis is requested for the diagnosis of BPH?	☐ 2.5 mg tablet - **Sign and date below** ☐ 5 mg tablet - **Sign and date below** ☐ 10 mg tablet - **STOP Coverage not approved** ☐ 20 mg tablet - **STOP Coverage not approved**	
5. Did the prostatectomy surgery occur less than 365 days ago?	☐ Yes **Sign and date below**	☐ No **STOP Coverage not approved**

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6. What is the indication or diagnosis?	☐ Raynaud's disease/phenomenon - Proceed to question **7** ☐ Preservation or restoration of erectile function after prostatectomy - Proceed to question **8** ☐ Other indication or diagnosis - **STOP Coverage not approved**	
7. What is the dosing regimen? -- Please Note: Document the dose and directions.	_____ **Sign and date below**	
8. Did the prostatectomy surgery occur less than 365 days ago?	☐ Yes **Sign and date below**	☐ No **STOP Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[29 Jul 2024]