

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Tadalafil-Adcirca - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at
1-410-424-4607. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the
Prior Authorization process.
When conditions are met, we will authorize the coverage of Tadalafil-Adcirca - Priority Partners MCO.

Drug Name (select from list of drugs shown)

Adcirca (tadalafil)

Alyq

Tadalafil

Quantity

Frequency

Strength

Route of Administration

Expected Length of Therapy

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

[If yes, skip to question 8.]

2. Does the patient have a definitive diagnosis of pulmonary arterial hypertension? Y N

NOTE: Submission of medical records is required.	
[If no, no further questions.]	
3. Was the diagnosis of pulmonary arterial hypertension confirmed by a cardiologist or pulmonologist by right heart catheterization?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
4. Does the patient have World Health Organization (WHO) Functional Class II or Class III symptoms?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
5. Has the pulmonary arterial hypertension progressed despite surgical treatment and/or maximal medical treatment?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
6. Has the patient had treatment failure with oral calcium channel blockers?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Patients who have substantial reductions in pulmonary arterial pressure from short acting vasodilators at the time of catheterization may require high doses (e.g., nifedipine 240 milligrams per day (mg/day) or amlodipine 20 mg/day) \ NOTE: Submission of medical records is required.	
[If yes, skip to question 9.]	
7. Is the patient unable to take oral calcium channel blockers, or is their use inappropriate in this patient?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, skip to question 9.]	
[If no, no further questions.]	
8. Is there clinical documentation showing the patient has experienced improved exercise capacity or a delay in symptom worsening?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
9. Is the patient receiving nitrate therapy?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
10. Is this a request for generic tadalafil?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, skip to question 13.]	
11. Has the patient previously failed an adequate trial of generic tadalafil?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, skip to question 13.]	
12. Does the patient have an intolerance to generic tadalafil?	<input type="checkbox"/> Y <input type="checkbox"/> N

NOTE: Submission of medical records is required.
[If no, no further questions.]
13. Will the requested drug be used in combination with one or more drugs with the same pharmacology when the patient has not adequately responded to monotherapy? <input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date
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