Levitra and Staxyn (vardenafil) Prior Authorization Request Form

JOHNS HOPKINS HEALTHCARE
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: ______________________ Physician Name: ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

Sponsor ID # ______________________ Phone #: ______________________

Date of Birth: Secure Fax #:

Step 2 **Please consider the following:**

- Patients taking nitrates, either regularly or intermittently, should not receive PDE-5 inhibitors. Patients should be informed of the consequences should they initiate nitrate therapy while taking a PDE-5 inhibitor.
- Please see product labeling precautions for concurrent use with alpha blockers.

Step 3 **1. Please indicate the patient's gender.**

Female	Please go to **Section 1** for **Female patients** on this page
Male	Please go to **Section 2** for **Male patients** on page 2

Section 1 – Female patients

1. Is the PDE-5 inhibitor being prescribed for the treatment of sexual dysfunction?	Yes **Coverage not approved**	No Proceed to Question **2**
2. Is the PDE-5 inhibitor being prescribed for a diagnosis of pulmonary arterial hypertension (PAH)?	Yes **SKIP** to Question **4**	No Proceed to Question **3**
3. Is the PDE-5 inhibitor being prescribed for a diagnosis of Raynaud's phenomenon?	Yes Proceed to Question **4**	No **Coverage not approved**
4. What is the dosing regimen?		

Please go to Step 4 on Page 2.

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Section 2 – Male patients

Question	Yes	No
1. Is vardenafil being prescribed for a diagnosis of pulmonary arterial hypertension (PAH)?	**Yes** **SKIP** to Question **9**	**No** Proceed to Question **2**
2. Is vardenafil being prescribed for treatment of Raynaud's phenomenon?	**Yes** **SKIP** to Question **9**	**No** Proceed to Question **3**
3. Is vardenafil being prescribed for preservation/restoration of erectile function after prostatectomy?	**Yes** **SKIP** to Question **9**[1]	**No** Proceed to Question **4**
4. Is the patient 40 years of age or older?	**Yes** **SKIP** to Question **6**	**No** Proceed to Question **5**
5. Is vardenafil being prescribed for the treatment of erectile dysfunction (ED) of organic origin or mixed organic/psychogenic origin, or drug-induced ED where the causative drug cannot be altered or discontinued?	**Yes** Proceed to Question **6**	**No** **STOP** **Coverage not approved**
6. Has the patient tried Viagra (sildenafil) and had an inadequate response?	**Yes** **Sign and date below**	**No** Proceed to Question **7**
7. Has the patient tried Viagra (sildenafil) but was unable to tolerate it due to adverse effects?	**Yes** **Sign and date below**	**No** Proceed to Question **8**
8. Is treatment with Viagra (sildenafil) contraindicated?	**Yes** **Sign and date below**	**No** **Coverage not approved**
9. What is the dosing regimen? **Please sign and date below**		

[1] Authorizations for preservation/restoration after prostatectomy are valid for 1 year.

Step 4 **I certify the above is correct and accurate to the best of my knowledge.** Please sign and date:

Prescriber signature ____________________ Date ____________

[18 April 2012]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: