Prior Authorization Request Form for
Sildenafil

JOHNS HOPKINS MEDICINE
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 and/or age.

Female	Please go to **Section 1** for **Female patients** ***below***
Male younger than 40 years of age	Please go to **Section 2** ***on next page***
Male 40 years of age and older	**Prior Authorization not required.**

Section 1 – Female patients

1. What is the indication or diagnosis?	☐ Sexual dysfunction – **STOP - Coverage not approved** ☐ Raynaud's phenomenon – proceed to question **2** ***in this section*** ☐ All other indications or diagnoses including pulmonary arterial hypertension – **STOP - Coverage not approved**
2. What is the dosing regimen? (Please document)	_____ **Sign and date on the next page**

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Section 2 – Male patients younger than 40 years of age

1. Is the patient 18 years of age or older?	☐ Yes Proceed to question **2**	☐ No Proceed to question **6**
2. Is generic sildenafil being prescribed for the treatment of erectile dysfunction of organic origin or mixed organic/psychogenic origin?	☐ Yes **Sign and date below**	☐ No Proceed to question **3**
3. Is generic sildenafil being prescribed for the treatment of drug-induced erectile dysfunction where the causative drug cannot be altered or discontinued?	☐ Yes **Sign and date below**	☐ No Proceed to question **4**
4. Is generic sildenafil being prescribed for preservation or restoration of erectile function following prostatectomy? (Note that authorization expires after 1 year for this indication)	☐ Yes Proceed to question **5**	☐ **No** Proceed to question **6**
5. Did the prostatectomy surgery occur less than 365 days ago?	☐ Yes Proceed to question **7**	☐ **No** **STOP** **Coverage not approved**
6. Is generic sildenafil being prescribed for a diagnosis of Raynaud's phenomenon?	☐ Yes Proceed to question **7**	☐ **No** **STOP** **Coverage not approved**
7. What is the dosing regimen? (Please document)	_____ **Sign and date below**	

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

_____ _____
Prescriber Signature Date

[03 June 2020]

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