Prior Authorization Request Form for
avanafil **(Stendra)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

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

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 Please complete the clinical assessment:

1. Is the patient male?	☐ Yes Proceed to question 2	☐ No **STOP** Coverage not approved
2. What is the indication or diagnosis?	☐ **Erectile dysfunction (ED)** – proceed to question 3 ☐ **Preservation / restoration of erectile function following prostatectomy** – proceed to question **7** ☐ **Other indication or diagnosis** – **STOP**: **Coverage not approved**	
3. Is the patient 40 years of age or older?	☐ Yes **SKIP** to question **5**	☐ No Proceed to question 4
4. Is the erectile dysfunction (ED) of organic origin or mixed organic/psychogenic origin, or drug-induced where the causative drug cannot be altered or discontinued?	☐ Yes Proceed to question 5	☐ No **STOP** Coverage not approved
5. Has the patient tried Viagra and had an inadequate response or was unable to tolerate it due to adverse effects?	☐ Yes Sign and date below	☐ No Proceed to question 6
6. Is treatment with Viagra (sildenafil) contraindicated?	☐ Yes Sign and date below	☐ No **STOP** Coverage not approved
7. What is the dosing regimen? [1]	Sign and date below	

[1] Authorization for preservation/restoration after prostatectomy is valid for 1 year.

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

Prescriber Signature _____ Date _____

[19 August 2015]

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