TRICARE Prior Authorization Request Form for
Tadalafil

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HEALTH PLANS
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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 such as Cialis. 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.
- Please note tadalafil for ED (erectile dysfunction) for daily use is not covered.

Step 3

1. Please indicate the patient's gender.

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

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?	

Sign and date on bottom of next page

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Section 2 – Male patients

1. How old is the patient?	☐ 18 years of age and older – Proceed to Question **2** ☐ Younger than 18 years of age – **STOP Coverage not approved**	
2. What is the indication or diagnosis?	☐ ED (erectile dysfunction) of organic origin – proceed to question **3** ☐ ED of mixed organic & psychogenic origin – proceed to question **3** ☐ ED that is drug-induced and the causative drug cannot be altered or discontinued – proceed to question **3** ☐ ED and benign prostatic hyperplasia (BPH) – proceed to question **5** ☐ Benign prostatic hyperplasia (BPH) – proceed to question **5** ☐ Preservation / restoration of erectile function after prostatectomy – proceed to question **8** (Note that authorization expires after 1 year for this indication) ☐ Raynaud's phenomenon – proceed to question **9** ☐ All other indications or diagnoses including pulmonary arterial hypertension – **STOP Coverage not approved**	
3. Has the patient tried generic sildenafil and had an inadequate response or intolerable adverse effects?	☐ Yes **Sign and date below**	☐ No Proceed to question **4**
4. Is treatment with generic sildenafil contraindicated?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
5. Is generic tadalafil being prescribed at a dose of 2.5 mg or 5 mg daily?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Has the patient tried tamsulosin [Flomax] or alfuzosin [Uroxatral] and had an inadequate response or intolerable adverse effects?	☐ Yes Proceed to question **9**	☐ No Proceed to question **7**
7. Is treatment with tamsulosin [Flomax] or alfuzosin [Uroxatral] contraindicated?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
8. Did the prostatectomy surgery occur less than 365 days ago?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. What is the dosing regimen?		

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: