## TRICARE Prior Authorization Request Form for Sildenafil Citrate suspension (Liqrev), Tadalafil suspension (Tadliq)



7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to:

(410) 424-4037

**S** 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.

1       Patient Name: Address:       Physician Name: Address:         Sponsor ID # Date of Birth:       Phone #: Secure Fax #:         Step       Please complete the clinical assessment:         1       What is the diagnosis or indication?         I       Who group 1 pulmonary arterial hypertension (PAH) – Proceed to question 2         I       What is the diagnosis or indication?         I       What is the diagnosis or indication?         I       WHO group 1 pulmonary arterial hypertension (PAH) – Proceed to question 2         I       Erectile dysfunction (ED) – STOP Coverage not approved         Image: protect of a pulmonologist?       Image: protect of the proceed to question 3         Stop       Coverage not approved         Image: proceed to question 3       STOP         Coverage not approved       No         Stop       Proceed to question 3         Stop       Coverage not approved         Image: provided to confirm that the patient has had a right heart catheterization?       Yes         Proceed to question 5       STOP         Coverage not approved       No         Stop       Proceed to question 5         Proceed to question 5       STOP         Coverage not approved       No         Proceed to question 5       STOP	Step	Please complete patient and physician information (please print):				
Address:	1	Patient Name:	Physician Name:	-		
Date of Birth:       Secure Fax #:         Step       Please complete the clinical assessment:         1       What is the diagnosis or indication?       WHO group 1 pulmonary arterial hypertension (PAH) – Proceed to question 2         Erectlic dysfunction (ED) – STOP Coverage not approved       Benign prostatic hyperplasia (BPH) – STOP Coverage not approved         2       Is the requested medication being prescribed by a cardiologist or a pulmonologist?       Yes       No         3       Has the patient had a right heart catheterization?       Yes       No         4       Is documentation being provided to confirm that the patient has had a right heart catheterization?       Yes       No         PLEASE NOTE: Medical documentation specific to your response to this question during use to attached to this case or your request could be denied. Documentation may include, but is not limited to, chart notes and       Yes       No	-					
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Step       Please complete the clinical assessment:         1. What is the diagnosis or indication?						
2       1. What is the diagnosis or indication?		Date of Birth:   Secure Fax #:				
Image: Second	Step	Please complete the clinical assessment:				
Proceed to question 2         □ Erectile dysfunction (ED) - STOP Coverage not approved         □ Benign prostatic hyperplasia (BPH) - STOP Coverage not approved         □ Other- Coverage not approved         2. Is the requested medication being prescribed by a cardiologist or a pulmonologist?         □ Other- Coverage not approved         3. Has the patient had a right heart catheterization?         □ Yes       □ No         Proceed to question 4       STOP         Coverage not approved         4. Is documentation being provided to confirm that the patient has had a right heart catheterization?       □ Yes         Proceed to question 5       STOP         Coverage not approved       No         4. Is documentation being provided to confirm that the patient has had a right heart catheterization?       □ Yes         Proceed to question 5       STOP         Coverage not approved       No         Proceed to question 5       STOP         Coverage not approved       No         Proceed to question 5       STOP         Coverage not approved       No	2	1. What is the diagnosis or indication?				
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2. Is the requested medication being prescribed by a cardiologist or a pulmonologist?						
cardiologist or a pulmonologist?       Proceed to question 3       STOP         Proceed to question 3       STOP         3. Has the patient had a right heart catheterization?       Yes       No         Proceed to question 4       STOP         Coverage not approved       Proceed to question 4       STOP         Coverage not approved       Proceed to question 4       STOP         Version       Proceed to question 4       STOP         Coverage not approved       Proceed to question 5       STOP         Posent to question 4       STOP       Coverage not approved         4. Is documentation being provided to confirm that the patient has had a right heart catheterization?       Yes       No         Proceed to question 5       STOP       Coverage not approved         PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Documentation may include, but is not limited to, chart notes and       Coverage not approved			□ Other- Coverage not approv	ed		
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	5.	Did the results of the right heart catheterization confirm the diagnosis of WHO Group 1 pulmonary	□ Yes	🗆 No	
		arterial hypertension (PAH)?	Proceed to question 6	STOP	
				Coverage not approved	
	6.	Is the patient receiving other phosphodiesterase inhibitors (PDE-5 inhibitors), nitrates, or riociguat	□ Yes	🗆 No	
		(Adempas) concomitantly?	STOP	Proceed to question 7	
			Coverage not approved		
	7.	Does the patient require a liquid formulation due to	□ Yes	□ No	
		swallowing difficulty?	Proceed to question 8	STOP	
				Coverage not approved	
	8.	Has the patient had an adequate trial and failed OR	□ Yes	🗆 No	
		has a contraindication to generic sildenafil suspension?	Sign and date below	STOP	
			Coverage not approved		
Step	l ce	I certify the above is true to the best of my knowledge. Please sign and date:			
3					
		Prescriber Signature	Date		
				[5 June 2023]	

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