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

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 complete the clinical assessment:**

1. What is the diagnosis or indication?	☐ WHO group 1 pulmonary arterial hypertension (PAH) – 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?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Has the patient had a right heart catheterization?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is documentation being provided to confirm that the patient has had a right heart catheterization? 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 catheterization laboratory reports.	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**

5. Did the results of the right heart catheterization confirm the diagnosis of WHO Group 1 pulmonary arterial hypertension (PAH)?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Is the patient receiving other phosphodiesterase inhibitors (PDE-5 inhibitors), nitrates, or riociguat (Adempas) concomitantly?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **7**
7. Does the patient require a liquid formulation due to swallowing difficulty?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Has the patient had an adequate trial and failed OR has a contraindication to generic sildenafil suspension?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

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

_______________________________ 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: