Prior Authorization Request Form for Viagra
(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** on this page
☐ Male younger than 40 years of age	Please go to **Section 2** on page 2
☐ Male 40 years of age and older	**Prior Authorization not required.**

Section 1 – Female patients

1. Is the PDE-5 inhibitor being prescribed for the treatment of sexual dysfunction?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 2**
2. Is the PDE-5 inhibitor being prescribed for a diagnosis of pulmonary arterial hypertension (PAH)?	☐ Yes **SKIP to Question 4**	☐ No **Proceed to question 3**
3. Is the PDE-5 inhibitor being prescribed for a diagnosis of Raynaud's phenomenon?	☐ Yes **Proceed to question 4**	☐ No **STOP** **Coverage not approved**
4. 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 5**
2. Is Viagra 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 Viagra 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 Viagra being prescribed for preservation or restoration of erectile function following prostatectomy?	☐ Yes **SKIP to question 7[A]**	☐ **No** **Proceed to question 5**
5. Is Viagra being prescribed for a diagnosis of Raynaud's phenomenon?	☐ Yes **SKIP to question 7**	☐ **No** **Proceed to question 6**
6. Is Viagra being prescribed for a diagnosis of pulmonary arterial hypertension (PAH)?	☐ Yes **SKIP to question 7**	☐ **No** **STOP** **Coverage not approved**
7. What is the dosing regimen? (Please document)	_____ **Sign and date below**	

Authorizations for preservation/restoration after prostatectomy are valid for 1 year.

Step 4

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

_____ Prescriber signature

_____ Date

[20 September 2018]

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