carolina complete health

## Pharmacy Prior Approval Request for Cialis

**Beneficiary Information**

1. Beneficiary Last Name:______________________ 2. First Name: ________________________________
3. Beneficiary ID #:____________________ 4. Beneficiary Date of Birth:______________ 5. Beneficiary Gender: _____

**Prescriber Information**

6. Prescribing Provider NPI #: ______________________________________________
7. Requester Contact Information:
   Name:_______________________________ Phone #:____________________________ Ext. ______________

**Drug Information**

8. Drug Name: **Cialis** 9. Strength:____________________ 10. Quantity per 30 days: _____________

11. Length of Therapy (in days): ☐ up to 30 days ☐ 60 days ☐ 90 days ☐ 120 days ☐ 180 days ☐ 365 days ☐ other

**Clinical Information**

****Cialis is not covered when prescribed to treat Erectile Dysfunction (ED)****

1. Is the beneficiary 18 years of age or older? ☐ Yes ☐ No
2. Is the beneficiary male? ☐ Yes ☐ No
3. Does the beneficiary have a confirmed diagnosis of Benign Prostatic Hyperplasia? ☐ Yes ☐ No
4. Is the beneficiary currently receiving an alpha blocker or nitrate? ☐ Yes ☐ No
5. Please list the preferred medications for Benign Prostatic Hyperplasia from the NC Medicaid and Health Choice preferred drug list (PDL) that the beneficiary has tried and failed:
   ___________________________________________________________________________________________
   ___________________________________________________________________________________________

Signature of Prescriber:___________________________________________ Date: ___________________

**(Prescriber Signature Mandatory)**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax all forms and lab work to: (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309
https://www.covermymeds.com/main/prior-authorization-forms/

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