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: _____ 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

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. Has the beneficiary tried and failed on at least two preferred medications (at least one alpha blocker and at least one hormone blocker) or does the beneficiary have a clinical reason or other contraindication as to why two preferred medications (at least one alpha blocker and at least one hormone blocker) cannot be tried?
   ☐ **Yes** ☐ **No** **Please list meds tried or clinical reason/contraindication as to why beneficiary cannot use preferred**

_____

_____

_____

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 this form to: (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309

https://www.covermymeds.com/main/prior-authorization-forms/

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