REALRx

PRIOR AUTHORIZATION REQUEST FORM

PHOSPHODIESTERASE-5 ENZYME (PDE-5) INHIBITORS FOR ERECTILE DYSFUNCTION

Sildenafil, Tadalafil

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ sildenafil tablets, ☐ tadalafil tablets

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐	
ERECTILE DYSFUNCTION (ED) **NOTE: Check Summary Plan Description (SPD) to determine if ED is a covered benefit**			
1. Is the member diagnosed with erectile dysfunction?	☐	☐	**Please provide documentation**
2. Is the member taking nitrates or guanylate cyclase stimulators?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated after initiation of therapy?	☐	☐	
3. Has the therapy shown to be effective with an improvement in condition?	☐	☐	**Please provide documentation**
4. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:
Physician's Signature:

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Policy PHARM- 057
Origination Date: 02/16/2018
Reviewed/Revised Date: 07/31/2023
Next Review Date: 07/31/2024
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