UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Cialis (tadalafil)

		Cialis (t	auaiaiii)
			cation Information required field
*Member ID:			*Member Name:
*DO	B:		*Weight:
*Me	dication Name/Strength:		 Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Dir	ections for use:		
			nformation equired field
*Requesting Provider Name:			*NPI:
*Add	dress:		
*Cor	ntact Person:		*Phone #:
*Fax	· #:		Email:
			: laboratory results, chart notes and/or updated 328-4992, to prevent processing delays.
Crite	eria for Approval: (ALL of the	following criteria must be	e met)
	Diagnosis of Benign Prostatic Hyperplasia described in chart note. Chart Note Page #:		
	Medication is not prescribed for the treatment of Erectile Dysfunction.		
☐ Trial and failure or contraindication of at least one preferred alpha-1 antagonist or 5 a		referred alpha-1 antagonist or 5 alpha-reductase inhibitor:	
	Medication:		Chart Note Page #:
	Dates of therapy:	Details of Failur	re:
NOT	E:		
*	• •	•	IDCs used for Benign Prostatic Hyperplasia (BPH). Please ation form for Alyq and Adcirca (tadalafil) NDCs.
*	Per federal regulation, Medicaid does not reimburse for drugs used for the treatment of sexual dysfunction or erectile dysfunction. Cialis prescriptions for Benign Prostatic Hyperplasia should have that diagnosis included on the prescription and pharmacies should dispense only those Cialis (tadalafil) NDCs with the BPH indication.		
	uthorization Criteria: ated letter with medical justifi	cation or updated chart	notes demonstrating positive clinical response.
	norization: Up to six (6) mont uthorization: Up to one (1) y		
PRO	VIDER CERTIFICATION		
I her	eby certify this treatment is ir	ndicated, necessary and	meets the guidelines for use.
Prescriber's Signature			 Date