



BlueCross BlueShield

CIALIS

Federal Employee Program. PRIOR APPROVAL REQUEST

Send completed form to: Service Benefit Plan Prior Approval P.O. Box 52080 MC 139 Phoenix, AZ 85072-2080 Attn: Clinical Services Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required) and Provider Information (required) form with fields for Date, Patient Name, Date of Birth, Sex, Street Address, City, State, Zip, Patient ID, Provider Name, Specialty, Office Phone, Office Fax, Office Street Address, City, State, Zip, and Physician Signature.

PHYSICIAN COMPLETES

Cialis 10mg and 20mg are excluded from coverage under the plan for male members. All strengths are excluded from coverage under the plan for female members. Please refer to the Blue Cross Blue Shield plan brochure for more information on the exclusion of the medication from coverage for the diagnosis of erectile dysfunction.

Cialis (tadalafil)

NOTE: Form must be completed in its entirety for processing

Please select strength: [] 2.5mg [] 5mg

**Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit

Is this request for brand or generic? [] Brand [] Generic

How many tablets will the patient need for a 90 day supply? _____ tablet(s) per 90 days

1. What is the patient's diagnosis?

[] Benign Prostatic Hyperplasia / Hypertrophy (BPH)

[] Erectile dysfunction

a. Does the patient have a concurrent diagnosis of benign prostatic hypertrophy? [] Yes [] No

[] Other diagnosis (please specify): _____

2. Is the patient assigned male at birth? [] Yes [] No

3. Will Cialis be used in combination with any nitrates in any form? [] Yes* [] No

*If YES, please specify medication: _____

4. Will the patient be using Cialis concurrently with a guanylate cyclase (GC) stimulator? [] Yes* [] No

*If YES, please specify medication: _____

5. Will the patient be using Cialis concurrently with Adcirca or Revatio? [] Yes [] No

6. Has the patient been on Cialis 2.5mg or 5mg continuously for the last 6 months, excluding samples? Please select answer below:

[] NO - this is INITIATION of therapy, please answer the following questions:

a. Is the patient actively symptomatic? [] Yes* [] No

*If YES, which symptom is the patient experiencing? Please select symptom(s) below:

[] Dribbling at the end of urinating

[] Straining to urinate

[] Pain with urination or bloody urine

[] Inability to urinate (urinary retention)

[] Urinary frequency

[] Slowed or delayed start of the urinary stream

[] Incomplete emptying of bladder

[] Weak urine stream

[] Strong and sudden urge to urinate

[] Incontinence

[] Nocturia (needing to urinate 2 or more times per night)

[] Other symptoms (please specify): _____

b. If Urinary Frequency: Is the patient experiencing the need to urinate 2 to 3 times per night? [] Yes [] No

c. Has the patient experienced treatment failure or a clinically significant adverse reaction to an alpha blocker? [] Yes [] No*

*If NO, has the patient experienced treatment failure or a clinically significant adverse reaction to a 5-alpha reductase inhibitor? [] Yes [] No

[] YES - this is a PA renewal for CONTINUATION of therapy, please answer the following question:

a. Has there been an improvement in the patient's urinary symptoms? [] Yes [] No



**BlueCross
BlueShield.**

Federal Employee Program.

CIALIS

PRIOR APPROVAL REQUEST


Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

<p>Electronically Online (ePA) Results in 2-3 minutes FASTEST AND EASIEST</p>	<p>Now you can get responses to drug Prior Authorization requests securely online. Online submissions may receive instant responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to Caremark.com/ePA.</p>
<p>Phone (4-5 minutes for response)</p>	<p>The FEP Clinical Call Center can be reached at (877)-727-3784 between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.</p>
<p>Fax (3-5 days for response)</p>	<p>Fax the attached form to (877)-378-4727. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. <u>Please only fax the completed form once as duplicate submissions may delay processing times.</u></p>

<p>faster... easier... better...</p>	<p>Introducing ePA! Online Prior Authorizations in minutes through Caremark.com/ePA. Sign up today!</p> <p>CVS/caremark </p>
---	---