HEALTH PLANS
UNIVERSITY OF UTAH

# PRIOR AUTHORIZATION REQUEST FORM
## PHOSPHODIESTERASE-5 ENZYME (PDE-5) INHIBITORS
Sildenafil, Tadalafil

**For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.**

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

| | | |
|---|---|---|
| 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, ☐ sildenafil solution, ☐ tadalafil tablets

Dosing/Frequency:_______________________________________________________________________________

**If the request is for reauthorization, proceed to reauthorization section**

| Questions | Yes | No | Comments/Notes |
|---|---|---|---|
| **PULMONARY HYPERTENSION** | | | |
| 1. Does the member have a diagnosis of Pulmonary Arterial Hypertension (PAH)? | ☐ | ☐ | **Please provide documentation** |
| 2. Is the member classified as WHO (World health Organization) Group 1 pulmonary arterial hypertension? If not, please provide the WHO group classification. | ☐ | ☐ | **Please provide documentation** |
| 3. For sildenafil solution, is the member ≤8 years of age and unable to swallow tablets? | ☐ | ☐ | **Please provide documentation** |
| 4. For tadalafil, has the member had at least a 3-month trial and failure of sildenafil with 1 month of therapy at the maximum tolerated dose? | ☐ | ☐ | **Please provide documentation** |
| **BENIGN PROSTATIC HYPERPLASIA (BPH)** | | | |
| 1. Is the patient 18 years of age or older? | ☐ | ☐ | |
| 2. Does the patient have an AUA-SI score of ≥8? | ☐ | ☐ | **Please provide documentation** |
| 3. Has the patient trialed and failed both an alpha1-blocker and a 5-alpha reductase inhibitor for at least a year? | ☐ | ☐ | **Please provide documentation** |
| 4. Does the patient have a planned cataract surgery in the next 3 months? | ☐ | ☐ | **Please provide documentation** |

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| ERECTILE DYSFUNCTION (ED)<br>NOTE: Check Summary Plan Description (SPD) to determine if ED is a covered benefit | | | |
|---|---|---|---|
| 1. Is the patient a male who is 40 years of age or older? | ☐ | ☐ | |
| 2. Is the patient diagnosed with Benign Prostatic Hyperplasia? | ☐ | ☐ | **Please provide documentation** |
| 3. Has the patient trialed and failed generic sildenafil? | ☐ | ☐ | **Please provide documentation** |
| **RAYNAUD'S SYNDROME** | | | |
| 1. Has the patient tried non-pharmacologic therapy? | ☐ | ☐ | **Please provide documentation** |
| 2. Has the patient tried and failed a calcium channel blocker? | ☐ | ☐ | **Please provide documentation** |
| 3. Has the patient tried and failed generic sildenafil? | ☐ | ☐ | **Please provide documentation** |
| **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: 08/19/2020
Next Review Date: 08/19/2021
Current Effective Date: 09/01/2020

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