



**Independence
Blue Cross**

**Prior Authorization Form
Erectile Dysfunction Agents**

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: **Viagra®** (sildenafil) **Levitra®** (vardenafil) **Cialis®** (tadalafil)
(check one) **MUSE®** (alprostadil) **Edex®** (alprostadil) **Caverject®** (alprostadil)
 Other (specify) _____

****Note: Quantity limit of 8 units per month. Different quantity limits may apply to some groups.****

Date: _____ Patient ID#: _____ DOB: _____
 Patient Name: _____ Provider NPI: _____
 Prescribing Physician: _____ Office Contact: _____
 Office Fax #: _____ Office Phone: _____

ONLY COMPLETED REQUESTS WILL BE REVIEWED

1. DIAGNOSIS FOR DRUG REQUESTED:

Erectile Dysfunction Other (specify) _____

2. PATIENT HISTORY:

- a. Is the patient on Nitrates (in the past 6 months) ? Yes No
- b. Does the patient have diabetes? Yes No
- d. History of prostate cancer treatment? Yes No
- e. History of pelvic surgery and/or radiation therapy? Yes No
 (specify): _____
- f. History of spinal cord injury? Yes No
 (specify): _____
- g. History of neurologic disease? Yes No
 (specify): _____
- h. Has the patient tried and failed or has a contraindication/intolerance/allergy to a Yes No
 testosterone containing product?

3. LABORATORY EVALUATION: (Required for patients less than 55 years old)

Serem testosterone level Free Total _____ Lab Normal Range _____ Not Done
 Prolactin level Test result _____ Lab Normal Range _____ Not Done

Please add any other supporting medical information that may be useful in the decision-making process:

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

Internal use only		Coverage effective date / /	
Document # _____		Processor Initials _____	Date _____
M F Rx coverage	Y N	STANDARD - SELECT	LOB _____
Previous Auth	Y N	Approved	Reviewer Initials _____ Date _____