Prior Authorization Form

Revatio® (Sildenafil)/Adcirca® (Tadalafil)

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: ☐ **Revatio®** ☐ **Adcirca®**

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:

☐ Pulmonary Hypertension
☐ Other (specify)________________________________

2. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

☐ **N/A** If none or not applicable to diagnosis, indicate "N/A."

Drug Name	Date	Duration

3. PATIENT HISTORY:

Is the patient currently taking nitrates? ☐ Yes ☐ No

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

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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_____________

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