Fax completed form to Navitus at: 855-668-8553
For questions, please call: 877-908-6023

TEXAS MEDICAID

Drug Prior Authorization
Phosphodiesterase Type 5 (PDE5) Inhibitors

Request Information (required)
This request is: ☐ **Expedited* (Urgent)** ☐ **Standard (Non-Urgent)** *Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

Member Information (required)			Prescriber Information (required)		
Member Name:			Prescriber Name:		
Member Insurance ID #:			NPI # :	Specialty:	
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

Please fill out the following information:
1. Medication Requested (Name): (Go to #2)

2. Quantity Requested:
(Go to #3)

3. Dose Requested (Strength):
(Go to #4)

4. Dosing Instructions:
(Go to #5)

Required Criteria

5. Provide primary diagnosis including ICD-10 code(s):
(Go to #6)

6. Please indicate the requested drug's formulary status: *(Formulary available at www.txvendordrug.com)

- ◯ Non-Preferred Drug (NPD or NAP)
  (Go to #7)
- ◯ Preferred Drug (PDL)
  (Go to #12)
- ◯ No Status, Drug is not in a Market Basket
  (Go to #12)
- ◯ N/A as this request is for a CHIP/PERINATE member
  (Go to #12)

Preferred Drug List (PDL) Criteria (required for non-preferred products)

7. Is this request for tadalafil 5mg tablet?

- ◯ Yes
  (Go to #8)
- ◯ No
  (Go to #9)

8. Has the member failed a 30-day treatment trial with at least one (1) preferred agent for benign prostatic hyperplasia (BPH) in the last 180 days?

- ◯ Yes
  (Go to #12)
- ◯ No
  (Go to #10)

9. Has the member failed a 14-day treatment trial with at least one (1) preferred agent for pulmonary arterial hypertension (PAH) in the last 180 days?

- ◯ Yes
  (Go to #12)
- ◯ No
  (Go to #10)

10. Is there a documented allergy or contraindication to preferred agents in this class?

- ◯ Yes
  (Go to #12)
- ◯ No
  (Go to #11)

11. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

- ◯ Yes
  (Go to #12)
- ◯ No (Deny)
  (Go to #12)

Clinical Criteria (required)

12. Does the member have a diagnosis of pulmonary hypertension (PH) in the last 180 days?

- ◯ Yes
  (Go to #15)
- ◯ No, and the request is for tadalafil 2.5, 5, or 10mg
  (Go to #13)
- ◯ No, and request is for any agent other than tadalafil 2.5, 5 or 10mg (Deny)
  (Go to #13)

13. Is the request for a male member?

- ◯ Yes
  (Go to #14)
- ◯ No (Deny)
  (Go to #14)

14. Does the member have a diagnosis of benign prostatic hyperplasia (BPH) in the last 730 days?

- ◯ Yes
  (Go to #15)
- ◯ No (Deny)
  (Go to #15)

15. Does the member have a history of using a denial drug (nitrates, alpha blockers, tamsulosin, or lopinavir/ritonavir) in the last 45 days?

Examples denial drugs include: ADEMPAS, alfuzosin ER (UROXATRAL), BIDIL, clarithromycin (BIAXIN), doxazosin (CARDURA), dutasteride/tamsulosin (JALYN), CRIXIVAN, INVIRASE, isosorbide dinitrate (DILATRATE-SR), isosorbide mononitrate, itraconazole (SPORANOX), KETEK, ketoconazole, lansoprazole/amoxicillin/clarithromycin (PREVPAC), lopinavir/ritonavir (KALETRA), nefazodone, nitroglycerin (NITRO-BID, NITRO-DUR, NITROLINGUAL, NITROMIST, NITROSTAT), NORVIR, NOXAFIL, prazosin (MINIPRESS), tamsulosin (FLOMAX), terazosin, VICTRELIS, VIEKIRA, VIRACEPT, and voriconazole (VFEND).

- ◯ Yes (Deny)
  (Go to #16)
- ◯ No
  (Go to #16)

16. Does the member have a history of a denial diagnosis (sickle cell disorders, multiple myeloma, leukemia, or cardiac condition) in the last 180 days?

- ◯ Yes (Deny)
  (Go to #17)
- ◯ No
  (Go to #17)

17. Does the member have a diagnosis of retinitis pigmentosa in the last 730 days?

- ◯ Yes (Deny)
  (Go to #18)
- ◯ No
  (Go to #18)

18. Based on the member's diagnosis, is the total daily dose less than or equal to (≤) 60mg (PH) or 5mg (BPH)?

- ◯ Yes (Approve - 365 days)
  (Go to #19)
- ◯ No (Deny)
  (Go to #19)

Additional Information

19. Please provide any additional information we should consider (or attach any supporting documents):
(END)

Submission Information (required)

Prescriber Signature: _____ **Date:** _____

**** PLEASE FAX COMPLETED FORM TO: 855-668-8553 ****

If criteria not met, submit chart documentation with form citing complex medical circumstances.
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