TEXAS MEDICAID
Clinical Edit Prior Authorization
Phosphodiesterase Type 5 (PDE5) Inhibitors

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: MEDICATION INFORMATION	
Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:

Patient's Primary Diagnosis: _____ ICD 10 Code: _____

Indicate the drug's formulary status: *(Formulary available at www.txvendordrug.com)

☐ Non-Preferred Drug **(NPD or NAP Status, Go to Step 3 - PDL PA Criteria Applies)**

OR ☐ Preferred Drug **(Go to Step 4)**

OR ☐ No Status, Drug is not in a Market Basket **(Go to Step 4)**

OR ☐ N/A as this request is for a CHIP / PERINATE client **(Go to Step 4)**

STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Is this request for tadalafil 5mg tablet?

   ☐ Yes (Go to #2) ☐ No (Go to #3)

2. Has the client 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 Step 4 Question 1) ☐ No (Go to #4)

3. Has the client 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 Step 4 Question 1) ☐ No (Go to #4)

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

☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #5)

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

☐ Yes (Go to Step 4 Question 1) ☐ No (Deny)

STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

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

☐ Yes (Go to #4)
☐ No, and request is for tadalafil 5mg (Go to #2)
☐ No, and request is for any agent other than tadalafil 5mg (Deny)

2. Is the request for a male client?

☐ Yes (Go to #3) ☐ No (Deny)

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

☐ Yes (Go to #4) ☐ No (Deny)

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

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

☐ Yes (Deny) ☐ No (Go to #5)

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

☐ Yes (Deny) ☐ No (Go to #6)

6. Does the client have a diagnosis of retinitis pigmentosa in the last 730 days?

☐ Yes (Deny) ☐ No (Go to #7)

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

☐ Yes (Approve – 365 days) ☐ No (Deny)

STEP 5: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.