

US Family Health Plan

Prior Authorization Request Form for avanafil (**Stendra**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID #: _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

Step 2 Please consider the following:

- Patients taking nitrates, either regularly or intermittently, should not receive PDE-5 inhibitors. Patients should be informed of the consequences should they initiate nitrate therapy while taking a PDE-5 inhibitor.
- Please see product labeling precautions for concurrent use with alpha blockers.

Step 3 Please complete the clinical assessment:

1. Is the patient male?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. What is the indication or diagnosis?	<input type="checkbox"/> Erectile dysfunction (ED) – proceed to question 3 <input type="checkbox"/> Preservation / restoration of erectile function following prostatectomy – proceed to question 7 <input type="checkbox"/> Other indication or diagnosis – STOP: Coverage not approved	
3. Is the patient 40 years of age or older?	<input type="checkbox"/> Yes SKIP to question 5	<input type="checkbox"/> No Proceed to question 4
4. Is the erectile dysfunction (ED) of organic origin or mixed organic/psychogenic origin, or drug-induced where the causative drug cannot be altered or discontinued?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
5. Has the patient tried Viagra and had an inadequate response or was unable to tolerate it due to adverse effects?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 6
6. Is treatment with Viagra (sildenafil) contraindicated?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
7. What is the dosing regimen? ¹		
_____ Sign and date below		

¹Authorization for preservation/restoration after prostatectomy is valid for 1 year.

Step 4 I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature	Date
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