

US Family Health Plan Prior Authorization Request Form for Viagra (sildenafil)

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: _____ Address: _____ Sponsor ID #: _____ Date of Birth: _____	Physician Name: _____ Address: _____ Phone #: _____ Secure Fax #: _____
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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 1. Please indicate the patient's gender and/or age.

Female	Please go to Section 1 for Female patients on this page
Male younger than 40 years of age	Please go to Section 2 on page 2
Male 40 years of age and older	Prior Authorization not required.

Section 1 – Female patients

1. Is the PDE-5 inhibitor being prescribed for the treatment of sexual dysfunction?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 2
2. Is the PDE-5 inhibitor being prescribed for a diagnosis of pulmonary arterial hypertension (PAH)?	<input type="checkbox"/> Yes SKIP to Question 4	<input type="checkbox"/> No Proceed to question 3
3. Is the PDE-5 inhibitor being prescribed for a diagnosis of Raynaud's phenomenon?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
4. What is the dosing regimen? (Please document)	_____ Sign and date on the next page	

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Section 2 – Male patients younger than 40 years of age

1. Is the patient 18 years of age or older?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No Proceed to question 5
2. Is Viagra being prescribed for the treatment of erectile dysfunction of organic origin or mixed organic/psychogenic origin?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 3
3. Is Viagra being prescribed for the treatment of drug-induced erectile dysfunction where the causative drug cannot be altered or discontinued?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 4
4. Is Viagra being prescribed for preservation or restoration of erectile function following prostatectomy?	<input type="checkbox"/> Yes SKIP to question 7^A	<input type="checkbox"/> No Proceed to question 5
5. Is Viagra being prescribed for a diagnosis of Raynaud's phenomenon?	<input type="checkbox"/> Yes SKIP to question 7	<input type="checkbox"/> No Proceed to question 6
6. Is Viagra being prescribed for a diagnosis of pulmonary arterial hypertension (PAH)?	<input type="checkbox"/> Yes SKIP to question 7	<input type="checkbox"/> No STOP Coverage not approved
7. What is the dosing regimen? (Please document)	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Sign and date below	

^A Authorizations for preservation/restoration after prostatectomy are valid for 1 year.

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

_____ Prescriber signature

_____ Date