US Family Health Plan
Prior Authorization Request Form for
Tadalafil (Cialis)

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 855-273-5735

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**

Clinical documentation may be required. Failure to provide could result in denial.

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 such as Cialis. 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.
- Please note tadalafil for ED (erectile dysfunction) for daily use is not covered.

Step 3

1. Please indicate the patient's gender and/or age.

Female	Please go to **Section 1** for **Female patients** ***below***
Male younger than 40 years of age	Please go to **Section 2** ***on next page***
Male 40 years of age and older	**Prior Authorization not required.** If this male patient requires daily dosing for benign prostatic hyperplasia (BPH), Raynaud's phenomenon or reservation/restoration of erectile dysfunction following prostatectomy, please contact Express-Scripts 866-684-4488 to complete a quantity review.

Section 1 – Female patients

1. What is the indication or diagnosis?	☐ Sexual dysfunction – **STOP - Coverage not approved** ☐ Raynaud's phenomenon – proceed to question **2** ***in this section*** ☐ All other indications or diagnoses including pulmonary arterial hypertension – **STOP - Coverage not approved**
2. What is the dosing regimen?	

Sign and date on bottom of next page

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Section 2 – Male patients

Question		
1. How old is the patient?	☐ Greater than or equal to 18 years of age – Proceed to Question **2** ☐ Younger than 18 years of age – **STOP Coverage not approved**	
2. What is the indication or diagnosis?	☐ ED (erectile dysfunction) of organic origin – **Sign and date below** ☐ ED of mixed organic & psychogenic origin – **Sign and date below** ☐ ED that is drug-induced and the causative drug cannot be altered or discontinued – **Sign and date below** ☐ ED and benign prostatic hyperplasia (BPH) – proceed to question **3** ☐ Benign prostatic hyperplasia (BPH) – proceed to question **3** ☐ Preservation / restoration of erectile function after prostatectomy – proceed to question **4** (Note that authorization expires after 1 year for this indication) ☐ Raynaud's phenomenon – proceed to question **5** ☐ All other indications or diagnoses including pulmonary arterial hypertension – **STOP Coverage not approved**	
3. Is generic tadalafil being prescribed at a dose of 2.5 mg or 5 mg daily?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
4. Did the prostatectomy surgery occur less than 365 days ago?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. What is the dosing regimen? ______________________________ **Sign and date below**		

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

________________________ Prescriber Signature

____________ Date

[12 April 2024]