BlueCross BlueShield Federal Employee Program

ENTADFI
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Entadfi

(finasteride and tadalafil)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

Will the patient need more than 1 capsule per day? ❑Yes* ❑No

If YES, please specify the requested quantity: _____ capsule(s) per day

1. Does the patient have a diagnosis of BPH (benign prostatic hyperplasia)? ❑Yes ❑No

2. Is the patient actively symptomatic? ❑Yes* ❑No

   If YES, which symptom is the patient experiencing? ***Please select symptom below:***

   ❑Dribbling at the end of urinating
   ❑Inability to urinate (urinary retention)
   ❑Incomplete emptying of bladder
   ❑Incontinence
   ❑Nocturia (needing to urinate 2 or more times per night)
   ❑Pain with urination or bloody urine
   ❑Slowed or delayed start of the urinary stream
   ❑Straining to urinate
   ❑Strong and sudden urge to urinate
   ❑Urinary frequency*
   ❑Weak urine stream
   ❑Other symptom ***(please specify)***:_____

3. ***Urinary Frequency**: Is the patient experiencing the need to urinate 2 or more times per night? ❑Yes ❑No

4. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to an alpha blocker? ❑Yes ❑No*

5. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 5-alpha reductase inhibitor? ❑Yes ❑No

6. Will Entadfi be used in combination with any nitrates in any form? ❑Yes* ❑No

   If YES, please specify the medication: _____

7. Will Entadfi be used in combination with a guanylate cyclase (GC) stimulator? ❑Yes* ❑No

   If YES, please specify the medication: _____