BlueCross BlueShield Federal Employee Program.

PDE5 INHIBITOR POWDERS
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					

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

Please select powder: ❑ **Sildenafil powder** ❑ **Tadalafil powder**

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

1. Which dosage form will the powder be compounded into? ***Please select dosage form below:***
   ❑Oral (capsule/suspension/tablet) ❑Topical (cream/gel/ointment/patch/solution)
   ❑Other dosage form ***(please specify)***: _____
2. Is the requested strength commercially available? ❑Yes ❑No
3. Which strength will the powder be compounded into per unit? _____ mg/unit
4. Is this medication being used for erectile or sexual dysfunction? ❑Yes ❑No
5. Will the compounded medication be used in combination with any form of nitrates? ❑Yes ❑No
6. Will the compounded medication be used in combination with another PDE-5 inhibitor? ❑Yes ❑No
7. Will the compounded medication be used in combination with guanylate cyclase (GC) stimulators? ❑Yes ❑No
8. What is the patient's diagnosis?
   ❑Benign prostatic hyperplasia / hypertrophy (BPH)
   a. Has the patient been on Tadalafil powder continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:
   i. Is the patient actively symptomatic? ❑Yes***** ❑No
   If YES, which symptom is the patient experiencing? ***Please select the symptom below:***
   ❑Dribbling at the end of urinating ❑Straining to urinate ❑Pain with urination or bloody urine
   ❑Inability to urinate (urinary retention) ❑Urinary frequency ❑Slowed or delayed start of the urinary stream
   ❑Incomplete emptying of bladder ❑Weak urine stream ❑Strong and sudden urge to urinate
   ❑Incontinence ❑Nocturia (needing to urinate 2 or more times per night)
   ❑Other symptoms ***(please specify)***: _____
   ii. **If Urinary Frequency**: Is the patient experiencing the need to urinate 2 or more times per night? ❑Yes ❑No
   iii. Has the patient experienced treatment failure or a clinically significant adverse reaction to an alpha blocker? ❑Yes ❑No*****
   If NO, has the patient experienced treatment failure or a clinically significant adverse reaction to a 5-alpha reductase inhibitor? ❑Yes ❑No
   ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
   i. Has there been an improvement in the patient's urinary symptoms? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑ Pulmonary arterial hypertension (PAH) - (WHO Group I)

a. Does the prescriber agree to counsel and evaluate the patient for sudden loss of vision or hearing associated with this medication? ❑Yes ❑No

b. **Tadalafil Powder Request**: Does the patient have severe hepatic impairment (Child-Pugh Class C)? ❑Yes ❑No*****
****If NO***, does the patient have severe renal impairment (creatinine clearance less than 30 mL/min)? ❑Yes ❑No

c. Will the compounded medication be used in combination with alpha blockers? ❑Yes ❑No

d. Has the patient been on this medication continuously for the last **6 months**, excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Which level of activity causes the patient to experience shortness of breath or fatigue? ***Please select answer below:***

❑ No symptoms or limitations in ordinary physical activity (Class I)
❑ Mild symptoms and slight limitations during ordinary physical activity (Class II)
❑ Marked limitation in activity due to symptoms, even during less than ordinary physical activity (Class III)
❑ Experienced shortness of breath and fatigue while at rest (Class IV)

ii. Has this medication been prescribed or recommended by a cardiologist or pulmonologist? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

i. Has the patient's symptoms improved or stabilized with therapy? ❑Yes ❑No

❑ Raynaud's syndrome

a. Does the prescriber agree to counsel and evaluate the patient for sudden loss of vision or hearing associated with Sildenafil powder? ❑Yes ❑No

b. Will the compounded medication be used in combination with alpha blockers? ❑Yes ❑No

c. Has the patient been on Sildenafil powder continuously for the last **6 months**, excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following question:

i. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to two of the following: calcium channel blockers, alpha adrenergic receptor blockers, or angiotensin II receptor antagonists? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

i. Has the patient's symptoms improved or stabilized with therapy? ❑Yes ❑No

❑ Other diagnosis ***(please specify):*** _____

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer.