BlueCross BlueShield Federal Employee Program

ADCIRCA / ALYQ
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

For Standard Option patients GENERIC Adcirca (tadalafil) and Alyq are preferred products. Please consider prescribing a preferred product. Standard Option patients who switch to generic Adcirca or Alyq will be eligible for 2 copays at no cost in the benefit year.

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

Please select medication: ❑**Adcirca (tadalafil)** ❑**Alyq (tadalafil)**

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

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

1. **BRAND Adcirca Request (Standard Option Patient)**: Would you like to switch the patient to a preferred product, tadalafil (**generic** Adcirca) or Alyq? ❑Yes, switch to tadalafil (**generic** Adcirca) ❑Yes, switch to Alyq ❑No, do not switch*****

   If NO, does the patient have an intolerance or contraindication to or have they had an inadequate treatment response to **BOTH** preferred products? ❑Yes***** ***(*If YES, please select answer below)*** ❑No

   ❑**Tadalafil (generic Adcirca) ONLY** ***(specify result)***: _____

   ❑**Alyq ONLY** ***(specify result)***: _____

   ❑**BOTH Preferred Products** ***(specify result)***: _____

2. **BRAND Adcirca Request (Standard Option):** Is there a clinical reason for not trying **BOTH** preferred products? ❑Yes***** ❑No

   If YES, specify clinical reason: _____

3. **GENERIC Adcirca (tadalafil) or Alyq Request (Standard Option Patient):** Is tadalafil (**generic** Adcirca) or Alyq being requested as a change from **BRAND** Adcirca to allow the member access to their copay benefit? ❑Yes ❑No

4. What is the patient's diagnosis?

   ❑ Pulmonary arterial hypertension (PAH) (WHO Group 1)

   ❑ Pulmonary hypertension

   a. What is the cause of the pulmonary hypertension? ***Please select answer below:***

   ❑Congenital heart disease (WHO Group 1)
   ❑Connective tissue disease (WHO Group 1)
   ❑Drugs or toxins induced (WHO Group 1)
   ❑Heritable PAH (WHO Group 1)
   ❑HIV infection (WHO Group 1)
   ❑Idiopathic/**Unknown** cause (WHO Group 1)
   ❑Portal hypertension (WHO Group 1)
   ❑Schistosomiasis (WHO Group 1)
   ❑Pulmonary veno-occlusive disease (PVOD) (WHO Group 1)
   ❑Pulmonary capillary hemangiomatosis (PCH) (WHO Group 1)
   ❑Persistent pulmonary hypertension of the newborn (PPHN) (WHO Group 1)
   ❑Left heart disease (WHO Group 2)
   ❑Lung disease or hypoxemia (WHO Group 3)
   ❑Chronic thrombotic or embolic disease (CTEPH) (WHO Group 4)
   ❑Unclear multifactorial mechanisms (WHO Group 5)
   ❑Other cause ***(please specify)***: _____

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

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS

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PAGE 2 - PHYSICIAN COMPLETES

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

5. Does the patient have severe hepatic impairment (Child-Pugh Class C)? ❑Yes ❑No

6. Does the patient have severe renal impairment defined as creatinine clearance less than 30 mL/min? ❑Yes ❑No

7. Does the prescriber agree to counsel and evaluate the patient for sudden loss of vision or hearing that is associated with Adcirca/ Alyq? ❑Yes ❑No

8. Will Adcirca/Alyq be used in combination with another phosphodiesterase-5 (PDE-5) inhibitor? ❑Yes* ❑No
   Examples include Viagra/Revatio (sildenafil), Cialis/Adcirca (tadalafil), Levitra/Staxyn (vardenafil), and Stendra (avanafil).
   ****If YES***, please specify medication: _____

9. Will Adcirca/Alyq be used in combination with Guanylate Cyclase (GC) Stimulators? ❑Yes* ❑No
   Examples include Adempas (riociguat) and Verquvo (vericiguat).
   ****If YES***, please specify medication: _____

10. Will Adcirca/Alyq be used in combination with alpha blockers? ❑Yes* ❑No
    Examples include alfuzosin (Uroxatral), doxazosin (Cardura/XL), prazosin (Minipress), silodosin (Rapaflo), tamsulosin (Flomax, Jalyn etc.), terazosin (Hytrin).
    ****If YES***, please specify medication: _____

11. Will Adcirca/Alyq be used in combination with nitrate medications (in any form)? ❑Yes* ❑No
    Examples include isosorbide dinitrate (Isordil), isosorbide mononitrate (Imdur, Ismo), nitroglycerin tablets, capsules, or patches (Nitro-Dur), and isosorbide dinitrate/hydralazine (BiDil).
    ****If YES***, please specify medication: _____

12. Has the patient been on Adcirca/Alyq continuously for the last **6 months**, excluding samples? ***Please select answer below:***

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

a. **Patient UNDER the age of 18**: Which NYHA functional class is the patient? ***Please select answer below:***
- ❑Asymptomatic (Class I)
- ❑Mild tachypnea or diaphoresis with feeding (Class II)
- ❑Marked tachypnea or diaphoresis with feeding, prolonged feeding time with growth failure or marked dyspnea on exertion (Class III)
- ❑Symptoms such as tachypnea, retractions, grunting, or diaphoresis at rest (Class IV)

b. **Age 18 or older**: What level of activity causes the patient to experience shortness of breath or fatigue? ***Select answer below:***
- ❑No symptoms and no limitations in ordinary physical activity (Class I)
- ❑Mild symptoms and slight limitation during ordinary activity (Class II)
- ❑Marked limitation in activity due to symptoms, even during less than ordinary activity (Class III)
- ❑Experiences shortness of breath and fatigue while at rest (Class IV)

c. Has Adcirca/Alyq been prescribed by or recommended by either a cardiologist or pulmonologist? ❑Yes ❑No

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

a. Have the patient's symptoms improved or stabilized? ❑Yes ❑No

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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.***