EXPRESS SCRIPTS®

Prior Authorization Form
Viagra

This form is based on Express Scripts standard criteria and may not be applicable to all patients; certain plans and situations may require additional information beyond what is specifically requested.
Additional forms available: www.express-scripts.com/pa

Fax completed form to **1-877-329-3760**
If this an **URGENT** request, please call 1-800-753-2851

Patient Information

Patient First Name: _____

Patient Last Name: _____

Patient ID#: _____

Patient DOB: _____

Patient Phone #: _____

Prescriber Information

Prescriber Name: _____

Prescriber DEA/NPI **(required)**: _____

Prescriber Phone #: _____

Prescriber Fax #: _____

Prescriber Address: _____

State: _____ Zip Code: _____

Primary Diagnosis: _____ ICD Code: _____

Please indicate which drug and strength is being requested:

☐ Viagra 25mg ☐ Viagra 50mg ☐ Viagra 100mg

Directions for use (i.e. QD, BID, PRN & Qty): _____

Please complete the clinical assessment:			
1. Does the patient have a diagnosis of erectile dysfunction?	☐ Yes	☐ No	
2. Is the patient taking nitrates (for example: nitroglycerin, isordil [isosorbide dinitrate], etc.)?	☐ Yes	☐ No	
3. If the diagnosis is prophylaxis after nerve-sparing radical prostatectomy (early penile rehabilitation), has the patient had a nerve-sparing radical prostatectomy within the previous 12 months? If yes, is the requested medication prescribed by a urologist? ☐ Yes ☐ No	☐ Yes	☐ No	☐ N/A
4. If the diagnosis is benign prostatic hypertrophy (BPH) has the patient tried an alpha-1-blocker [for example, doxazosin (Cardura XL), terazosin (Hytrin), tamsulosin (Flomax), alfuzosin extended-release (UroXatral] OR a 5-alpha-reductaste inhibitor[for example, finasteride (Proscar), dutasteride (Avodart)]?	☐ Yes	☐ No	☐ N/A

5. If the diagnosis is high-altitude pulmonary edema (HAPE), treatment or prevention (for prevention must have a history of HAPE) [men or women], has the patient tried one other pharmacologic therapy (i.e., nifedipine, salmeterol, dexamethasone, acetazolamide, tadalafil) for treatment or prevention of HAPE? If yes, please list other therapies: _____	☐ Yes	☐ No	☐ N/A
6. If the diagnosis is Raynaud disease (men or women), has the patient tried at least TWO of any of the following therapies for Raynaud disease or ONE Vasodilator? If yes, please indicate: ☐ Alpha-adrenergic blockers (for example: Minipress, Prazosin) ☐ Angiotensin converting enzyme (ACE) inhibitors ☐ Calcium channel blockers (for example: amlodipine, felodipine, isradipine, nifedipine) ☐ Cozaar ☐ Fluoxetine ☐ Nitroglycerin ☐ ONE vasodilator (for example: Flolan [intravenous epoprostenol], Edex [alprostadil for injection], Tracleer). please indicate: _____ ☐ Other: _____	☐ Yes	☐ No	☐ N/A

Are there any other comments, diagnoses, symptoms, and/or any other information the physician feels is important to this review?

_____

_____

_____

Prescriber Signature: _____Date: _____

Office Contact Name: _____ Phone Number: _____

Based upon each patient's prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact our prior authorization team at the number listed on the top of this form.

Prior Authorization of Benefits is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for the patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.