



Prior Authorization Form

Erectile Dysfunction Agents

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: [] Viagra® (sildenafil) [] Levitra® (vardenafil) [] Cialis® (tadalafil) [] Staxyn® (vardenafil)
[] MUSE® (alprostadil) [] Edex® (alprostadil) [] Caverject® (alprostadil)
[] Other (specify) _____

Note: Quantity limit of 8 units per month. Different quantity limits may apply to some groups.

Date: _____ Patient ID#: _____ DOB: _____
Patient Name: _____ Provider NPI: _____
Prescribing Physician: _____ Office Contact: _____
Office Fax #: _____ Office Phone: _____

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1. DIAGNOSIS FOR DRUG REQUESTED:

[] Erectile Dysfunction [] Other (specify) _____

2. PATIENT HISTORY:

- a. Is the patient on Nitrates (in the past 6 months)? [] Yes [] No
b. Is the patient on Nitrates? Specify dates _____ [] Yes [] No
c. Does the patient have diabetes? [] Yes [] No
d. History of prostate cancer treatment? [] Yes [] No
e. History of pelvic surgery and/or radiation therapy? [] Yes [] No
(specify): _____
f. History of spinal cord injury? [] Yes [] No
(specify): _____
g. History of neurologic disease? [] Yes [] No
(specify): _____
h. Has the patient tried and failed or has a contraindication/intolerance/allergy to a testosterone containing product? [] Yes [] No

3. LABORATORY EVALUATION: (Required for patients less than 55 years old)

Serem testosterone level [] Free [] Total _____ Lab Normal Range _____ [] Not Done
Prolactin level Test result _____ Lab Normal Range _____ [] Not Done

Please add any other supporting medical information that may be useful in the decision-making process:

FAX: (888) 671-5285 or EMAIL: FSS_Standard_Medicare@catalystx.com
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL