1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Impotence Agents Prior Authorization Request Form (Page 1 of 2)

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:
- ❑ Benign prostatic hyperplasia (BPH)
- ❑ Drug-induced erectile dysfunction (ED)
- ❑ ED secondary to an underlying condition
- ❑ Other diagnosis:_____ICD-10 Code(s): _____

Drug-induced ED:
Select the medication(s) that is responsible for the patient's ED:
- ❑ Anticonvulsant (e.g., Carbamazepine, phenytoin)
- ❑ Antidepressant (e.g., Tricyclic antidepressants, selective serotonin reuptake inhibitors, trazodone, MAO inhibitors)
- ❑ Antipsychotic (e.g., Phenothiazines)
- ❑ Anxiolytic (e.g., Short-acting barbiturates, benzodiazepines)
- ❑ Cardiovascular drugs (e.g., Thiazide diuretics, spironolactone, methyldopa, clonidine, guanabenz, guanfacine, atenolol, metoprolol, pindolol, propranolol, doxazosin, prazosin, terazosin, phenoxybenzamine, hydralazine, nifedipine, diltiazem, verapamil, disopyramide)
- ❑ Gastrointestinal drug (e.g., Cimetidine, ranitidine, metoclopramide)
- ❑ Other medication: _____

Please answer the following:
Does the physician confirm that the drug is causing the patient's ED? ❑ **Yes** ❑ **No**
Is it possible to switch or discontinue the ED-causing drug? ❑ **Yes** ❑ **No**

ED secondary to an underlying condition:
What is the underlying condition [e.g., atherosclerosis, cardiac disease (e.g., hypertension, peripheral arterial disease), diabetes, central nervous system disease, multiple sclerosis, renal disease, hypogonadism, history of cystectomy, prostate cancer, spinal injuries] that is responsible for the patient's ED? _____
Does the physician confirm that the underlying condition is causing the patient's ED? ❑ **Yes** ❑ **No**

Benign prostatic hyperplasia:
Does the patient have a history of failure, contraindication, or intolerance to two alpha blockers [e.g., Flomax (tamsulosin), Rapaflo (silodosin), Uroxatral (alfuzosin)]? ❑ **Yes** ❑ **No**

Quantity limit requests:
What is the quantity being requested per month: _____

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

Please note: This request may be denied unless all required information is received.
Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.
Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	