



Adcirca (Tadalafil)

Prior Authorization Form Curascript Fax (888) 773-7386

Form with fields: Last Name, First Name, Prescriber's Name, Specialty, Home Phone, Work Phone, Office Phone, Office Fax, Home Address, City, State, ZIP, Address, City, State, ZIP, SCAN ID number, Date of Birth, Est. Start Date, Office Contact, For Specialty Medications Only: Shipping Address (if different from home address) [ ] Physician [ ] Home, Special Instructions (i.e. Non-English Speaking Patient, etc.):

Medication: \_\_\_\_\_ Diagnosis: \_\_\_\_\_
Sig: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_ ICD 9 Code: \_\_\_\_\_

Secondary/ Supplemental Insurance Company Phone Name of Insured ID Number Group Number

- 1. Is the indication for the treatment of Pulmonary Arterial Hypertension (PAH): World Health Organization (WHO) Group 1 to improve exercise ability?
2. Is Adcirca being prescribed by Pulmonologist or Cardiologist?
3. Is the member concurrently taking nitrates (nitroglycerin, isosorbide mononitrate, isosorbide dinitrate, Nitroquick, Nitrostat or others)?
4. Is the member concomitantly using potent CYP 3A inhibitors, such as ketoconazole and itraconazole?
5. Will Adcirca be co-administered with PDE5 inhibitors, such as Cialis, Viagra, etc?
6. Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?

Physician's Signature: \_\_\_\_\_ NPI/DEA #: \_\_\_\_\_ Date: \_\_\_\_\_

For Internal Use Only
[ ] Approved [ ] Denied Reviewer's Initials \_\_\_\_\_ Decision Date \_\_\_\_\_
Comments \_\_\_\_\_