PDE-5 Inhibitors Prior Authorization of Benefits Form

Texas | Medicaid

Contains confidential patient information.

Instructions

Complete this form in its entirety and fax to:
Prior Authorization of Benefits Center at **844-474-3341**.

1. Patient information	2. Physician information
Patient name:	Prescribing physician:
Patient ID No.:	Physician address:
Patient DOB:	Physician phone No.:
Date of Rx:	Physician fax No.:
Patient phone No.:	Physician specialty:
Patient email address:	Physician DEA:
	Physician NPI No.:
	Physician email address:

3. Medication	4. Strength	5. Directions	6. Quantity per 30 days
			Specify:

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7. Diagnosis

8. Approval criteria

Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.

☐ Yes ☐ No	Is the medication being provided and billed at the physician's office?
☐ Yes ☐ No	Does the patient have a diagnosis of pulmonary hypertension in the last 180 days?
☐ Yes ☐ No	Does the patient have a history of using a denial drug (nitrates, alpha blockers, tamsulosin, or lopinavir/ritonavir) in the past 45 days?
☐ Yes ☐ No	Does the patient have a history of a denial diagnosis (sickle cell disorders, multiple myeloma, leukemia, or cardiac condition) in the last 180 days?
☐ Yes ☐ No	Based on the client's diagnosis, is the total daily dose less than or equal to (≤) the maximum daily dose?
☐ Yes ☐ No	Does the patient have a diagnosis of retinitis pigmentosa in the last 730 days?
☐ Yes ☐ No	Does the client have a diagnosis of benign prostatic hyperplasia (BPH) in the last 730 days?
☐ Yes ☐ No	Patient has failed a 30-day treatment trial with at least one preferred agent(s) within the past 180 days.
☐ Yes ☐ No	Patient has a documented allergy or contraindication to preferred agents in this class.
☐ Yes ☐ No	Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.

For the *Texas Medicaid Preferred Drug List,* please refer to the Texas Medicaid Vendor Drug Program website at **txvendordrug.com/formulary/formulary-search**.

9. Physician signature

Prescriber or authorized signature	**Date**

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

The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Payment is subject to member eligibility. Authorization does not guarantee payment.

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