

**Adcirca (tadalafil)**  
**Prior Authorization Request Form**

Caterpillar Prescription Drug Benefit  
Phone: 877-228-7909 Fax: 800-424-7640

**Instructions:** Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

**URGENT**

MEMBER INFORMATION		
LAST NAME:	FIRST NAME:	
PHONE NUMBER:	DATE OF BIRTH:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
PATIENT INSURANCE ID NUMBER:		

MALE  FEMALE    HEIGHT (IN/CM): \_\_\_\_\_    WEIGHT (LB/KG): \_\_\_\_\_    ALLERGIES: \_\_\_\_\_

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: [PRIMETHERAPEUTICS.COM/NOPP](https://www.primetherapeutics.com/nopp)

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): \_\_\_\_\_  
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: \_\_\_\_\_

PRESCRIBER INFORMATION		
LAST NAME:	FIRST NAME:	
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:	
NPI NUMBER:	DEA NUMBER:	
PHONE NUMBER:	FAX NUMBER:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

*Continued on next page.*

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MEMBER'S LAST NAME: \_\_\_\_\_ MEMBER'S FIRST NAME: \_\_\_\_\_

<b>1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?</b> <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
<b>MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):</b>	<b>DURATION OF THERAPY (SPECIFY DATES):</b>	<b>RESPONSE/REASON FOR FAILURE/ALLERGY:</b>
<b>2. LIST DIAGNOSES:</b>		<b>ICD-10:</b>
<input type="checkbox"/> Pulmonary arterial hypertension (PAH) <input type="checkbox"/> Raynaud's phenomenon <input type="checkbox"/> Diagnosis _____ ICD-10 Code(s): _____		
<b>3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.</b>		
<p><b>For pulmonary arterial hypertension, answer the following:</b></p> <p>Does the patient have a diagnosis of Group 1 pulmonary arterial hypertension (PAH)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Select if the diagnosis of Group 1 pulmonary arterial hypertension (PAH) is caused by one of the following etiologies:*</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chronic hemolytic anemia</li> <li><input type="checkbox"/> Congenital heart disease(e.g. atrial-septal defect)</li> <li><input type="checkbox"/> Associated with surgical repair of a congenital systemic-to-pulmonary shunt of at least 1year in duration(e.g., ventricular septal defect, patent ductus arteriosus)</li> <li><input type="checkbox"/> Drugs and toxins induced (not reactive to acute vasoreactivity testing(AVT) or failed calcium channel blocker)CCB treatment)</li> <li><input type="checkbox"/> HIV infection</li> <li><input type="checkbox"/> Idiopathic/primary PAH</li> <li><input type="checkbox"/> Portal hypertension</li> <li><input type="checkbox"/> Schistosomiasis</li> <li><input type="checkbox"/> Tissue disease (e.g., lupus/SLE, RA scleroderma, systemic sclerosis, CREST syndrome, polymyositis, polyarteritis nodosa, mixed connective tissue disease)</li> </ul> <p><i>*Please provide documentation.</i></p> <p>Does the patient have WHO functional class II, III, or IV?* <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>*Please provide documentation.</i></p> <p>Is patient's diagnosis confirmed by cardiac catheterization? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does patient have, (at rest), measured by cardiac catheterization a mean pulmonary artery pressure(mPAP of 20mmHg or greater via right heart cath to confirm PAH? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please provide documentation.</i></p> <p>Does patient have, (at rest), measured by cardiac catheterization a pulmonary capillary wedge pressure(PCWP) 15mmHg or less via right heart cath to confirm PAH? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please provide documentation.</i></p> <p>Does patient have, (at rest), measured by cardiac catheterization a pulmonary vascular resistance(PVR) value equaling 3 wood units or greater via right heart cath to confirm PAH? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please provide documentation.</i></p>		

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If patient has idiopathic PAH, hereditary PAH (excludes congenital heart disease like atrial=septal defect) or drug/toxin induced PAH, did patient have had an acute vasoreactivity test?  Yes  No *\*Please provide documentation.*

Has patient been previously treated with a Calcium channel blocker?  Yes  No *\*Please provide documentation.*

Select the prescribing physician's specialty:

- Cardiology
- Nephrology
- Pulmonology
- Rheumatology

Does patient have a history of left-sided heart disease?  Yes  No

Does patient have severe renal insufficiency?  Yes  No

Does patient have pulmonary hypertension related to conditions other than previously specified?  Yes  No

For Raynaud's phenomenon, answer the following:

Is the prescribing physician a rheumatologist?  Yes  No

Is the patient's Raynaud's phenomenon secondary to systemic sclerosis/scleroderma?\*  Yes  No  
*\*Please provide documentation.*

Has the patient received prior treatment with, and is intolerant of or resistant to, at least one calcium channel blocker?\*  Yes  No  
*\*Please provide documentation.*

Will the patient be using a calcium channel blocker on alternate days with Adcirca?  Yes  No

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

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**Please note:** Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

**ATTESTATION:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature or Electronic I.D. Verification:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**FAX THIS FORM TO:** 800-424-7640

**MAIL REQUESTS TO:** Prime Therapeutics Management Prior Authorization Program

Attn: CP – 4201

P.O. Box 64811

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