Tadliq (tadalafil susp)
Prior Authorization Request Form

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

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

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

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:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Pulmonary Arterial Hypertension(PAH) ☐ Other diagnosis: _____ICD-10_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Is the drug going to be used in conjunction with a clinical trial? ☐ Yes ☐ No

Is prescriber a pulmonologist, cardiologist, nephrologist, or rheumatologist? ☐ Yes ☐ No

Does patient have WHO Group 1 Pulmonary Arterial Hypertension (PAH), defined as being caused by one of the following etiologies? ☐ Yes ☐ No please provide documentation.

☐ Idiopathic / primary (PAH)

☐ Drugs and toxins induced(not reactive to acute vasoreactivity testing(AVT) or failed calcium channel blocker)CCB treatment)

☐ Tissue disease(e.g.,Lupus/SLE, RA scleroderma, systemic sclerosis, CREST syndrome, polymyositis, polyarteritis nodosa, mixed connective tissue disease)

☐ HIV infection

☐ Portal hypertension

☐ Congenital heart disease (e.g. atrial-septal defect)

☐ 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)

☐ Schistosomiasis

☐ Chronic hemolytic anemia

Is patient WHO functional class II thru IV? ☐ Yes ☐ No please provide documentation.

Does patient have a mean pulmonary artery pressure(mPAP) equaling 25mmHg or greater? ☐ Yes ☐ No Please provide cardiac catheterization report.

Does patient have a pulmonary capillary wedge pressure(PCWP) equaling 15mmHg or less? ☐ Yes ☐ No Please provide cardiac catheterization report.

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Does patient have a pulmonary vascular resistance(PVR) equaling 3 Wood units via right heart cath or greater? □ Yes □ No Please provide cardiac catheterization report.

Does patient have a history of left-sided heart disease? □ Yes □ No please provide documentation
Does patient have severe renal insufficiency? □ Yes □ No please provide documentation

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:** Not all drugs/diagnoses 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: _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

Last Updated: 2/1/2023