



NC DHB Pharmacy Request for Prior Approval - Cialis

Recipient Information		
Recipient Last Name:	2. First Name	o:
3. Recipient ID #		5. Recipient
Gender:		
rayer iniormation		
6. Is this a Medicaid or Health Choice Red	quest? Medicaid:	Health Choice:
Prescriber Information		
7. Prescribing Provider #:		☐ <i>or</i> Atypical: ☐
8. Prescriber DEA #:		
Requester Contact Information		
Name:	Phone #:	Ext:
Drug Information		
9. Drug Name: Cialis 10. Strength	: 11. Quantity I	Per 30 Days:
12. Length of Therapy (in days): up to 30 60 90 120 180 365 Other:		
Clinical Information		
** Cialis is not covered when prescribed to treat Erectile Dysfunction (ED)**		
1. Is the beneficiary 18 years of age or older? Yes No		
2. Is the beneficiary male?		
3. Does the beneficiary have a confirmed diagnosis of Benign Prostatic Hyperplasia? Yes No		
4. Is the beneficiary currently receiving an alpha blocker or nitrate? Yes No		
5. Please list the preferred medications for Benign Prostatic Hyperplasia from the NC Medicaid and Health Choice preferred drug list (PDL) that the beneficiary has tried and failed:		
Signature of Prescriber:	Date:_	

*Prescriber signature mandatory

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: (800) 678-3189 Pharmacy PA Call Cer

Pharmacy PA Call Center: (866) 799-5318