AmeriHealth Caritas™
New Hampshire

Benign Prostatic Hyperplasia (BPH) Medications (Currently Cialis® Only)

Prior Authorization Drug Approval Form

Date of medication request: (MM/DD/YYYY): ____ / ____ / ______

Patient information and medication requested	
Patient's name:	Medicaid number:
Date of birth:	Gender:
Drug name:	Strength:
Dosing directions:	Length of therapy:

Prescriber information	
Prescriber last name:	Prescriber first name:
Prescriber address:	Prescriber representative:
Specialty:	NPI number:
Phone #:	Fax #:

Clinical history
1. Patient's diagnosis for use of this medication:
2. Has the patient failed a trial of an alpha blocker and an androgen hormone inhibitor? ☐ Yes ☐ No Please list medications and dates of trials:
3. Will the patient be on concurrent nitrate, alpha blocker, Revatio, Adcirca or guanylate cyclase stimulator? ☐ Yes ☐ No
Provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

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.