MHCSI
The Pharmacy Benefits Specialists

Strictly Confidential

ERECTILE DYSFUNCTION MEDICATION Prior Authorization Form

Fax completed form to 1-902-481-7114

Or Mail to: MHCSI, 201 Brownlow Avenue, Unit 20
Dartmouth, NS B3B 1W2

This form must be completed **IN FULL** and submitted to MHCSI to permit authorization for coverage of an erectile dysfunction medication on your employer-sponsored drug plan. Coverage will be granted if criteria are met and erectile dysfunction medications are benefits of your plan. Approvals may be subject to quantity or dollar limits as per plan design.

PATIENT INFORMATION

NAME:___________________________________DATE OF BIRTH ___ _____________________
(PLEASE PRINT)

ADDRESS:____
(STREET/MAILBOX) (CITY)

____
(PROVINCE) (POSTAL CODE)

MHCSI CARD NUMBER:___________________________/___________________________________
(GROUP #) (CERTIFICATE OR CLIENT#)

I hereby authorize my physician/nurse practitioner and/or pharmacist to provide the information necessary to complete this form on my behalf for request of coverage of medication for erectile dysfunction by my drug plan.

SIGNATURE:____ DATE:_____________________

CRITERIA FOR COVERAGE

Patients are eligible for coverage of approved erectile dysfunction medications if they meet the following criteria:

1. A confirmed diagnosis of erectile dysfunction (the consistent inability to attain or sustain an erection sufficient for sexual intercourse) due to one or more of several recognized etiologies.

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TO BE COMPLETED BY THE PHYSICIAN/NURSE PRACTITIONER (NP) and/or PHARMACIST IN CONSULTATION WITH THE PHYSICIAN/NURSE PRACTITIONER

Dear Doctor/NP/Pharmacist: We appreciate you providing information on this patient's medical condition and medication history which is required by the drug plan sponsor for authorization of claims for erectile dysfunction medications. Please complete the following sections of this form IN FULL. Any costs incurred in the completion of this form are the responsibility of the patient.

Medication Requested -generic brand may be used where available		
Drug Name	**Strength**	**DIN**
Viagra (sildenafil citrate) tablets	❑ 25 mg ❑ 50 mg ❑ 100 mg	❑ 02239766 ❑ 02239767 ❑ 02239768
Cialis (tadalafil) tablets Cialis Once-a day (tadalafil) tablets	❑ 10 mg ❑ 20 mg ❑ 2.5mg ❑ 5mg	❑ 02248088 ❑ 02248089 ❑ 02296888 ❑ 02296896
Levitra (vardenafil) tablets	❑ 5 mg ❑ 10 mg ❑ 20 mg	❑ 02250462 ❑ 02250470 ❑ 02250489
Caverject (alprostadil) injections	❑ 10 mcg ❑ 20 mcg	❑ 02215179 ❑ 02215187
MUSE (medicated intraurethral delivery system)	❑ 125 mcg ❑ 250 mcg ❑ 500 mcg ❑ 1000 mcg	❑ 02238592 ❑ 02238593 ❑ 02238594 ❑ 02238595
Other, please specify:		

This patient has a confirmed diagnosis of erectile dysfunction (the consistent inability to attain or sustain an erection sufficient for sexual intercourse) due to:

_____ Documented side effect from (a) medically necessary prescription medication(s)
Please specify:____

_____ Diabetes mellitus (on oral hypoglycemics or insulin therapy)
_____ Aorta-iliac disease with evidence of decreased blood flow (e.g. abnormal Doppler studies or absent pulses)
_____ Post radical prostatectomy and radiation of the prostate
_____ Neurological injury or disease (e.g. Multiple Sclerosis, spinal cord injury)
_____ Documented endocrine abnormalities (i.e. low testosterone)
_____ Psychiatric disorder for which medication and/or treatment is being received
_____ Other , Please specify:
____

In addition to the above, the patient:

_____Yes _____ No Has received a prescription for any form of nitrates in the past 6 months. If yes, and your request is for Viagra, Cialis or Levitra, please document the circumstances in the space provided:

____

_____ Yes _____ No Is currently receiving active therapy for erectile dysfunction with any of the following: intracavernosal injections, MUSE, Viagra, Cialis, Levitra, yohimbine, vacuum device, penile implant.

Physician/NP Name/Signature:	**Phone:**	**Date:**
Pharmacist Name/Signature:	**Store # & Location/ Phone # :**	**Date:**

OFFICE USE ONLY		
Approval ☐ **Accepted** ☐ **Declined**	**Date**	**Quantity**
	Approved by	**and/or End date**
Extension possible ☐ **Yes** ☐ **No**		