

**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. Approval will apply to all medications in the erectile dysfunction category up to plan quantity and/or dollar amount as per plan design. Once approval is granted, coverage will automatically reset yearly based on calendar or benefit year, and according to quantity/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#)

**Coordination of benefits (COB):**  NO  YES If yes, Name of Coordinating Plan \_\_\_\_\_

If MHCSI, please provide: \_\_\_\_\_ / \_\_\_\_\_  
(GROUP #) (CERTIFICATE OR CLIENT#)

Is this drug being covered by the coordinating plan?  NO  YES

*I hereby authorize any licensed prescriber, other healthcare professional, institution, insurance company, patient access program, plan sponsor/administrator and MHCSI to exchange information in connection with this claim for the purpose of Prior Authorization evaluation, adjudication of claims, and administration of my drug benefit program. A photocopy of this authorization shall be as valid as the original. I certify that the information in this form is true and complete.*

Signature <b>X</b>	Date(YYYY/MM/DD)
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**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 MEDICAL PRACTITIONER**

Dear Prescribing Medical Practitioner: 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	<input type="checkbox"/> 25 mg	<input type="checkbox"/> 02239766
	<input type="checkbox"/> 50 mg	<input type="checkbox"/> 02239767
	<input type="checkbox"/> 100 mg	<input type="checkbox"/> 02239768
Cialis (tadalafil) tablets	<input type="checkbox"/> 10 mg	<input type="checkbox"/> 02248088
	<input type="checkbox"/> 20 mg	<input type="checkbox"/> 02248089
Cialis Once-a day (tadalafil) tablets	<input type="checkbox"/> 2.5mg	<input type="checkbox"/> 02296888
	<input type="checkbox"/> 5mg	<input type="checkbox"/> 02296896
Levitra (vardenafil) tablets	<input type="checkbox"/> 5 mg	<input type="checkbox"/> 02250462
	<input type="checkbox"/> 10 mg	<input type="checkbox"/> 02250470
	<input type="checkbox"/> 20 mg	<input type="checkbox"/> 02250489
Staxyn (vardenafil) orally disintegrating tablet	<input type="checkbox"/> 10mg	<input type="checkbox"/> 02372436
Caverject (alprostadil) injections	<input type="checkbox"/> 10 mcg	<input type="checkbox"/> 02215179
	<input type="checkbox"/> 20 mcg	<input type="checkbox"/> 02215187
MUSE (medicated intraurethral delivery system)	<input type="checkbox"/> 125 mcg	<input type="checkbox"/> 02238592
	<input type="checkbox"/> 250 mcg	<input type="checkbox"/> 02238593
	<input type="checkbox"/> 500 mcg	<input type="checkbox"/> 02238594
	<input type="checkbox"/> 1000 mcg	<input type="checkbox"/> 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.

Prescriber Name/Signature:		Phone:		Date:
Pharmacist Name/Signature:		Store # & Location/ Phone # :		Date:
<b>OFFICE USE ONLY</b>				
Approval	<input type="checkbox"/> Accepted	Date	Quantity	
	<input type="checkbox"/> Declined	Approved by	and/or End date	Processing Number
Extension possible <input type="checkbox"/> Yes <input type="checkbox"/> No				