

NC Medicaid
Pharmacy Prior Approval Request for
Cialis



Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): up to 30 Days 60 Days 90 Days 120 Days 180 Days 365 Days Other _____

Clinical Information

1. Is the Beneficiary 18 years of age or older? Yes No
2. Is the beneficiary male? Yes No
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. Has the beneficiary tried and failed on at least two preferred medications (at least one alpha blocker and at least one hormone blocker) or does the beneficiary have a clinical reason or other contraindication as to why two preferred medications (at least one alpha blocker and at least one hormone blocker) cannot be tried?
 Yes No **Please list meds tried or clinical reason/contraindication as to why beneficiary cannot use preferred**

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.