



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



Prior Authorization Request Form

Magellan: Fax: 1-888-603-7696 Phone: 1-866-675-7755

Date of Medication Request: ____/____/____

Section I: Patient Information and Medication Requested

Name (Last, First): _____

NH Medicaid Number: _____

Date of Birth: ____/____/____

Gender: Male Female

Drug Name: _____ Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Section II: 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. Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page. _____

Section III: Prescriber Information

Name: _____ NPI Number: _____

Phone Number: (____) _____ - _____ Fax Number: (____) _____ - _____

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.

Signature of Prescribing Provider