Blue Cross Blue Shield of Vermont and The Vermont Health Plan
Prior Approval Form
Cialis® 5mg ONLY (tadalafil) FOR BPH USE ONLY

(Will not be reviewed for ED use)

BCBSVT/TVHP Fax # (888)–255-1006

PLEASE COMPLETE THE FOLLOWING SECTIONS:

Date of Request _____ Patient Name: _____

Member ID#:_____ Date of Birth: _____

Provider Name:_____ Provider Phone: _____

Provider Fax: _____ PCP Name: _____

INDICATIONS FOR USE	YES Yes	NO No
Initial therapy ☐ Renewal of existing therapy ☐ Answer question 6		
1. Is patient ≥ 18 years of age?	☐	☐
2. Has patient had a trial and failure of tamsulosin? **Or**	☐	☐
3. Has patient had a trial and failure of finasteride?	☐	☐
4. Is patient taking concomitant Nitrates?	☐	☐
5. Does patient have history of retinal disorder?	☐	☐
6. Is patient experience an improvement in the signs and symptoms of their BPH??	☐	☐

Initial approval will be for a 3-month period. If patient has demonstrated a response to therapy within this period, an additional 12 months will be authorized. Lack of improvement within the first 3 months warrants re-evaluation of patient therapy. DISPENSE IN ONLY 30 DAY SUPPLIES

PRESCRIBER SIGNATURE_____ DATE_____

By signing above, the prescriber confirms all information provided is accurate and verifiable via member records.

www.bcbsvt.com

BlueCross BlueShield of Vermont

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VERMONT Health PLAN