Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Tadalafil (BPH) - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q2. Will the patient take tadalafil in combination with either of the following: A) organic nitrates, or B) guanylate cyclase (GC) stimulators (e.g., riociguat)?

☐ Yes ☐ No

Q3. Is the patient being treated for erectile dysfunction (ED) in the absence of benign prostatic hyperplasia (BPH)?

☐ Yes ☐ No

Q4. Is there documentation showing a diagnosis of benign prostatic hyperplasia (BPH)?

☐ Yes ☐ No

Q5. Has the patient had an inadequate response or inability to tolerate one alpha blocker (such as tamsulosin, silodosin, alfuzosin)?

☐ Yes ☐ No

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Member Name:	**Prescriber Name:**

Q6. Has the patient had an inadequate response or inability to tolerate one 5-alpha-reductase inhibitor (such as dutasteride, finasteride)?

☐ Yes ☐ No

Q7. Requested Duration:

☐ 12 Months ☐ Other

Q8. Additional Information:

_____ _____

Prescriber Signature Date

v2025