Adcirca, Tadliq (Alyq, tadalafil 20mg)

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What drug is being prescribed?
   ❑ Adcirca ❑ Alyq ❑ Tadliq ❑ tadalafil 20mg ❑ Other _____
2. What is the diagnosis?
   ❑ Pulmonary arterial hypertension (PAH)
   ❑ Secondary Raynaud's phenomenon
   ❑ Erectile dysfunction
   ❑ Other _____
3. What is the ICD-10 code? _____
4. If brand Adcirca is being prescribed, is the prescriber willing to switch to tadalafil 20mg or Alyq?
   If Yes, fax a new prescription to the pharmacy and skip to #8.
   ❑ Yes - tadalafil 20mg ❑ Yes - Alyq ❑ Tadliq ❑ No
   ❑ Not applicable - brand Adcrica is not being requested, *skip to #8*
5. Has the patient failed treatment with the generic medication due to an intolerable adverse event (e.g., rash, nausea, vomiting)? ❑ Yes ❑ No
6. Was the intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the brand and generic medication)? ❑ Yes ❑ No
7. Was this documented in the patient's chart? ***ACTION REQUIRED: Documentation is required for approval. Provide SPECIFIC and DETAILED chart documentation including description, date/time, and severity of the adverse event, dosage and duration of generic medication treatment, required intervention (if any), and relevant tests or laboratory data (if any) OR MedWatch form of this trial and failure including the adverse reaction.*** ❑ Yes ❑ No
8. Is the request for continuation of therapy with the requested medication?
   ❑ Yes ❑ No *If No, skip to diagnosis section*
9. Is the patient currently receiving the requested medication through a paid pharmacy or medical benefit?
   ❑ Yes ❑ No ❑ Unknown *If No or Unknown, skip to diagnosis section*

Send completed form to: Case Review Unit CVS Caremark Prior Authorizatons Fax: 1-866-249-6155

10. Is the patient experiencing a benefit from therapy with the requested medication as evidenced by disease stability or disease improvement? ❑ Yes ❑ No *No further questions*

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Pulmonary Arterial Hypertension (PAH)

11. What is the World Health Organization (WHO) classification of pulmonary hypertension?
    - ❑ **WHO Group 1** (Pulmonary arterial hypertension)
    - ❑ **WHO Group 2** (Pulmonary hypertension owing to left heart disease)
    - ❑ **WHO Group 3** (Pulmonary hypertension owing to lung disease and/or hypoxia)
    - ❑ **WHO Group 4** (Chronic thromboembolic pulmonary hypertension)
    - ❑ **WHO Group 5** (Pulmonary hypertension with unclear multifactorial mechanisms)

12. Has PAH been confirmed by right heart catheterization? ❑ Yes ❑ No *If No, skip to #16*

13. What is the pretreatment mean pulmonary arterial pressure at rest? _____ mmHg

14. What is the pretreatment pulmonary capillary wedge pressure? _____ mmHg

15. What is the pretreatment pulmonary vascular resistance? _____ Wood units *No further questions*

16. Has Doppler echocardiogram been performed to diagnose PAH? ❑ Yes ❑ No

Section B: Secondary Raynaud's Phenomenon

17. Has the patient had an inadequate response to one of the following medications?
    - ❑ Calcium channel blockers
    - ❑ Angiotensin receptor blockers
    - ❑ Selective serotonin reuptake inhibitors
    - ❑ Alpha blockers
    - ❑ Topical nitrates
    - ❑ Other _____

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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