CIGNA
Pharmacy Services
Phone: (800)244-6224
Fax: (800)390-9745

CIGNA HealthCare Prior Authorization Form
- Erectile Dysfunction Medications -

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

PROVIDER INFORMATION			PATIENT INFORMATION		
* Provider Name:			**Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed**		
Specialty:	* DEA or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* CIGNA ID:		
Office Fax:			* Date Of Birth:		
* Is your fax machine kept in a secure location? Yes ☐ No ☐ * May we fax our response to your office? Yes ☐ No ☐			* Patient Street Address:		
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		

Medication requested:

☐ VIAGRA 25mg ☐ VIAGRA 50mg ☐ VIAGRA 100mg
☐ CIALIS 5mg ☐ CIALIS 10mg ☐ CIALIS 20mg
☐ LEVITRA 2.5mg ☐ LEVITRA 5mg ☐ LEVITRA 10mg ☐ LEVITRA 20mg
☐ MUSE 125mcg ☐ MUSE 250mcg ☐ MUSE 1000mcg
☐ EDEX ***(strength)*** ☐10mcg ☐ 20mcg ☐40mcg ***(dosage)*** ☐kit ☐vial ☐ampule
☐ CAVERJECT ***(strength)*** ☐5mcg ☐10mcg ☐20mcg ☐40mcg ***(dosage)*** ☐kit ☐vial ☐ampule

Diagnosis related to use:

☐ Erectile Dysfunction ☐ PAH (Pulmonary Arterial Hypertension) ☐ Other (please specify):

If Diagnosis is Erectile Dysfunction, please indicate origin of erectile dysfunction:

☐ Hormonal –
Have the appropriate labs been assessed and found to be normal? ☐ Yes ☐ No
If the labs abnormal, please specify treatment for correction:

☐ Neurogenic or Vasculargenic:
Please specify ICD-9 code:

☐ Pelvic Trauma:
Please specify the nature of the trauma:

☐ Is the cause Pharmacological in nature? ☐ Yes ☐ No
If *Yes*, has the patient had failure, contraindication or intolerance to at lease ONE formulary alternative drug that is not known to cause Erectile Dysfunction? ☐ Yes ☐ No
If *Yes*, please list medications:

If Diagnosis is PAH: *(please note, only Viagra is approvable for this diagnosis)*
Does the patient have a failure, contraindication or intolerance to TRACLEER or FLOLAN? ☐ Yes ☐ No

Please fax completed form to (800)390-9745. Phone requests may be submitted by calling (800)244-6224.
Our standard response time for prescription drug coverage requests is 2-4 business days. If your request is urgent, it is important that you call Pharmacy Services to expedite the request. View our formulary on line at http://www.cigna.com.

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