



**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 <input type="checkbox"/> No <input type="checkbox"/>			* Patient Street Address:		
* May we fax our response to your office? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		

**Medication requested:**

- |   |                                      |                                       |  |
|---|--------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> VIAGRA 25mg          | <input type="checkbox"/> VIAGRA 50mg | <input type="checkbox"/> VIAGRA 100mg |  |
| <input type="checkbox"/> CIALIS 5mg           | <input type="checkbox"/> CIALIS 10mg | <input type="checkbox"/> CIALIS 20mg  |  |
| <input type="checkbox"/> LEVITRA 2.5mg        | <input type="checkbox"/> LEVITRA 5mg | <input type="checkbox"/> LEVITRA 10mg | <input type="checkbox"/> LEVITRA 20mg  |
| <input type="checkbox"/> MUSE 125mcg          | <input type="checkbox"/> MUSE 250mcg | <input type="checkbox"/> MUSE 500mcg  | <input type="checkbox"/> MUSE 1000mcg  |
| <input type="checkbox"/> EDEX (strength)      | <input type="checkbox"/> 10mcg       | <input type="checkbox"/> 20mcg        | <input type="checkbox"/> 40mcg (dosage) <input type="checkbox"/> kit <input type="checkbox"/> vial <input type="checkbox"/> ampule |
| <input type="checkbox"/> CAVERJECT (strength) | <input type="checkbox"/> 5mcg        | <input type="checkbox"/> 10mcg        | <input type="checkbox"/> 20mcg   |

**Diagnosis related to use:**

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

**If Diagnosis is Erectile Dysfunction (ED), please indicate origin of erectile dysfunction:**

- Hormonal:  
Has appropriate therapy been given to address abnormal testosterone, prolactin, or thyroid levels?  Yes  No  
If No, does the patient have a contraindication to the therapy needed to correct the abnormal levels?  Yes  No
- Neurogenic or Vasculargenic:  
Please specify ICD-9 code:  
If the ICD-9 code is for Erectile Dysfunction of organic origin (607.84), please specify the cause:
- Pelvic Trauma:  
Please specify the nature of the trauma:
- Pharmacological:  
If the ED is being caused by a medication the patient is taking; has there been a failure, contraindication, or intolerance to an alternate medication that does not cause ED?  Yes  No
- If Yes, please list medications:
- Other (please specify):

**If Diagnosis is PAH: (please note, only Viagra is approvable for this diagnosis)**

- Does the patient have a failure, contraindication or intolerance to REVATIO?  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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