



NC DMA Pharmacy Request for Prior Approval -
Cialis



Recipient Information

DMA-3485 (V.01)

1. Recipient Last Name: _____ 2. First Name: _____
3. Recipient ID # _____ 4. Recipient Date of Birth: _____ 5. Recipient Gender: _____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: Health Choice:

Prescriber Information

7. Prescribing Provider #: _____ NPI: or Atypical:
8. Prescriber DEA #: _____
Requester Contact Information
Name: _____ Phone #: _____ Ext: _____

Drug Information

9. Drug Name: **Cialis** 10. Strength: _____ 11. Quantity Per 30 Days: _____
12. Length of Therapy (in days): up to 30 60 90 120 180 365 Other: _____

Clinical Information

**** Cialis is not covered when prescribed to treat Erectile Dysfunction (ED)****

1. Is the beneficiary 18 years of age or older? Yes No
2. Is the beneficiary male? Yes No
3. Does the beneficiary have a confirmed diagnosis of Benign Prostatic Hyperplasia? Yes No
4. Is the beneficiary currently receiving an alpha blocker or nitrate? Yes No
5. Please list the preferred medications for Benign Prostatic Hyperplasia from the NC Medicaid and Health Choice preferred drug list (PDL) that the beneficiary has tried and failed:

Signature of Prescriber: _____ Date: _____

*Prescriber signature mandatory

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to CSRA at: (855) 710-1969

Pharmacy PA Call Center: (866) 246-8505