

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Medicare Part D Sildenafil

Phone: 800-728-7947

Fax back to: 866-880-4532

Scott & White Prescription Services 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 left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Supervising Physician:	
Date of Birth:	Fax:	Phone:
Group Number:	Office Contact:	
Address:	NPI:	State Lic ID:
City, State ZIP:	Address:	
Primary Phone:	City, State ZIP:	
	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

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

Q1. What diagnosis is this drug being prescribed for (pick one)?

- Pulmonary arterial hypertension (PAH)
- Erectile dysfunction
- Other (Please specify)

Q2. Please provide ICD code(s) for diagnosis

Q3. Additional Comments

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Patient Name:	Prescriber Name: Supervising Physician:
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Prescriber Signature

Date

Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

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