NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Cialis

Beneficiary Information

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

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. ____

Drug Information

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

Clinical Information

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.