

**TADALAFIL (Cialis®) for
Benign Prostatic Hyperplasia (BPH)
PRIOR REVIEW/CERTIFICATION FAXBACK FORM**

**INCOMPLETE FORMS MAY DELAY PROCESSING
ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT BCBSNC PROVIDER ID# BELOW**

PRESCRIBER INFORMATION		PATIENT INFORMATION	
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME	
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID	
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH	
PRACTICE ADDRESS	CITY	STATE	ZIP

Please answer the following questions: **Dx Code:** _____

Quantity being requested per 30 days: _____

Physician specialty _____

- Is Cialis 5mg once daily being prescribed? Yes No
- Is/Was the initial prescription being written by a urologist after consultation? Yes No
- Is Cialis being prescribed for a male ≥ 45 years of age? Yes No
- Is erectile dysfunction the sole diagnosis for use of Cialis? Yes No
- Has the patient had a total prostatectomy? Yes No
- Are BPH signs and symptoms present? Yes No
- Is the patient's AUA-SI score less than 8? Yes No
- Has the patient failed therapy with or cannot tolerate standard BPH medical therapy with alpha blockers and 5-alpha reductase inhibitors? Yes No
- Will Cialis be used in combination with nitrates? Yes No

For Continuation Therapy, please answer questions 1-11:

- What was the patient's AUA-SI score prior to beginning therapy? _____
- What is the patient's AUA-SI score now? _____

Please certify the following by signing and dating below:

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required): _____ Date: _____

For BCBSNC Members, Fax Form to 1-800-795-9403