BlueCross BlueShield Federal Employee Program

Adcirca
PRIOR APPROVAL REQUEST

Send completed form to:
Blue Shield of California
Fax: 1-855-895-3504

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form. All incomplete and illegible forms will be returned to the patient.

CARDHOLDER / PATIENT INFORMATION

Cardholder Name: _____ / _____ / _____
First MI Last

Patient Name: _____ / _____ / _____
First MI Last

Patient Address: _____
Street City State Zip

Patient Date of Birth: ____ / ____ / ____ Sex: M ____ F ____

R | | | | | | | | | |
Cardholder Identification Number

PHYSICIAN COMPLETES

Adcirca (tadalafil)

NOTE: Form must be completed in its entirety for processing

1. What is the patient's **diagnosis**?
   - ☐ **Pulmonary arterial hypertension (PAH), also known as familial or idiopathic (WHO Group 1)**
   - ☐ **Pulmonary hypertension: *please check cause of PH:***

     - ☐ Collagen vascular disease
     - ☐ Portal hypertension
     - ☐ Exposure to drugs/toxins
     - ☐ Glycogen storage disease
     - ☐ Hereditary hemorrhagic telangiectasia
     - ☐ Myeloproliferative disorder
     - ☐ Pulmonary veno-occlusive disease
     - ☐ Left heart disease (WHO Group II)
     - ☐ Congenital systemic-to-pulmonary shunts
     - ☐ HIV infection
     - ☐ Thyroid disorder
     - ☐ Gaucher's disease
     - ☐ Hemoglobinopathies
     - ☐ Splenectomy
     - ☐ Pulmonary-capillary hemangiomatosis
     - ☐ Lung disease (WHO Group III)

   - ☐ Chronic thrombotic or embolic disease (WHO Group IV)
   - ☐ Unknown
   - ☐ Other cause (please specify): _____

   - ☐ **Other diagnosis *(please specify):*** _____

2. Is this **Initiation** of therapy? ☐Yes ☐No – this is the **Continuation** of therapy (Renewal of PA)

3. What level of physical activity causes shortness of breath or fatigue? ***(please select one of the following below)***
   - ☐No symptoms and no limitations in ordinary physical activity (Class I*)
     If Class I, was the patient previously Class II and has improved due to Adcirca therapy? ☐Yes ☐No
   - ☐Mild symptoms and slight limitation during ordinary activity (Class II)
   - ☐Marked limitation in activity due to symptoms, even during less than ordinary activity (Class III)
   - ☐Experiences shortness of breath and fatigue while at rest (Class IV)

4. Will the patient be concurrently using nitrate medications (in any form)? ☐Yes ☐No

5. Will the patient be concurrently using phosphodiesterase inhibitors? ☐Yes ☐No

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification.
Prescriber Certification: I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer,

_____ (_____) _____ (_____) _____
Physician Name (Print Clearly) Phone Fax

_____ _____ _____ _____
Street Address City State Zip

_____ _____ _____ / _____ / _____
Prescriber's NPI Physician Signature Date