



**New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form**

Benign Prostatic Hyperplasia (BPH) Medications (*Currently Cialis® 5 mg only*)

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

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MEDICAID ID NUMBER:

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DATE OF BIRTH:

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GENDER: Male Female

Drug Name

Strength

Dosing Directions

Length of Therapy

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

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FAX NUMBER:

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SECTION III: CLINICAL HISTORY

- Patient's diagnosis for use of this medication: _____
- Has the patient failed a trial of an alpha blocker and an androgen hormone inhibitor? Yes No
 - Please list medications and dates of trials: _____
- Will the patient be on concurrent nitrate, alpha blocker, Revatio, Adcirca or guanylate cyclase stimulator? Yes No
- Is there any additional information that would help in the decision-making process? **If additional space is needed, please use another page.**

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.

PRESCRIBER'S SIGNATURE: _____ DATE: _____