Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Cialis

Member Information

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

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: **Cialis** 2. Strength: _____ 3. Quantity per 30 Days: _____
4. 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 member 18 years of age or older? ☐ **Yes** ☐ **No**
2. Is the member male? ☐ **Yes** ☐ **No**
3. Does the member have a confirmed diagnosis of Benign Prostatic Hyperplasia? ☐ **Yes** ☐ **No**
4. Is the member 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 member 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.