ProCare Rx

Revatio™ sildenafil citrate

Date/Time of Request: Date: ______________ Time: ________________

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of Revatio™ (sildenafil citrate). Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. – Member Information:

Patient Name:	Plan Name:	
Patient ID:	Patient Date of Birth:	Patient Contact Phone#:

B. – Physician Information

Physician Name:		Physician Address:	
Physician DEA #:		Physician Phone #:	Physician Fax Number:
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC#:

C. – Pharmacy Information

Pharmacy Name:	NABP #:	Pharmacy Phone Number:	Pharmacy Fax Number:

D. – Clinical Information: Please fill out the following clinical information: (circle all that apply)

1. Does the patient have a diagnosis of pulmonary arterial hypertension (PAH) with WHO Group I? YES NO
2. Is the patient concurrently on nitrate therapy either regularly or intermittently? YES NO
3. Is the patient currently on ritonavir? YES NO

DOSING GUIDELINES: = The recommended dose of Revatio is 20mg TID, taken 4-6 hours apart with or without food. In clinical trials no greater efficacy was achieved with the use of higher doses. Treatment with doses higher than 20mg TID is not recommended. Dosage adjustment may be necessary when co-administering Revatio™ with CYP3A4 inhibitors (including; bosentan, and more portent inducers such as barbiturates, carbamazepine, phenytoin, efavirenz, nevirapine, and rifampin).

Authorized Medical Signature:			
Telephone:		**Date:**	

When Completed Return To: ProCare PBM Clinical Division 3891 Commerce Parkway Miramar, FL 33025 **1-800-662-0586 / Fax # 866-999-7736**

Receipt Date/Time of Completed Request:________________ FOR INTERNAL USE ONLY

Ticket Number: ___________

☐ **Approved** ☐ **Denied** ☐ **Denial Recommended**

Reviewed by: _____________ **Effective Date:**________________

Review Date: _____________ **Termination Date:** ______________

Review Time: _____________

(Date/Time)

Member Contacted:________________

MD Contacted:____________________

Pharmacy Contacted:________________

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes. *Created 01/2006*