MHCSI
The Pharmacy Benefits Specialists

ERECTILE DYSFUNCTION MEDICATION Prior Authorization (PA)
Strictly Confidential

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Mail: MHCSI, 201 Brownlow Avenue, Unit 20, Dartmouth, NS B3B 1W2

TO BE COMPLETED BY EMPLOYEE – PATIENT INFORMATION

This form must be completed **IN FULL** and submitted to MHCSI to permit authorization for coverage of an erectile dysfunction medication on your employer-sponsored drug plan. Coverage will be granted if criteria are met and erectile dysfunction medications are benefits of your plan. Approval will apply to all medications in the erectile dysfunction category up to plan quantity and/or dollar amount as per plan design. Once approval is granted, coverage will automatically reset yearly based on calendar or benefit year, and according to quantity/dollar limits as per plan design.

Member Name :	Group #	Certificate or Client ID #
Street Address:	City:	
Province:	Postal Code:	Phone # ( )
Patient Name:	Date of Birth:	

Do you or any dependents have other coverage under any other plan ☐ Yes ☐ No **(If Yes, complete the following)**

Name of other Insurer:_____ Member Name: _____

ID #: _____ Policy #: _____

Is this drug covered by coordinating plan? ☐ Yes ☐ No

I hereby authorize any licensed prescriber, other healthcare professional, institution, insurance company, patient access program, plan sponsor/administrator and MHCSI to exchange information in connection with this claim for the purpose of Prior Authorization evaluation, adjudication of claims, and administration of my drug benefit program. A photocopy of this authorization shall be as valid as the original. I certify that the information in this form is true and complete.

Signature (patient 14 yr. and older/parent/legal guardian) **X**	**Date (YYYY/MM/DD)**

TO BE COMPLETED BY MEDICAL PRACTITIONER - DRUG/DIAGNOSTIC INFORMATION

Medication Requested	Dosage/Dosing Interval	DIN
Quantity Requested		
Anticipated Length of Therapy		

Is this Request for: Initial Coverage _____ Continuation _____

INFORMATION SUPPORTING REQUIREMENT FOR THIS MEDICATION

Criteria

This patient has a confirmed diagnosis of erectile dysfunction (the consistent inability to attain or sustain an erection sufficient for sexual intercourse) due to:

☐ Documented side effect from (a) medically necessary prescription medication(s)
*Please specify:*_____
☐ Diabetes mellitus (on oral hypoglycemics or insulin therapy)
☐ Coronary Artery disease
☐ Post radical prostatectomy and radiation of the prostate
☐ Neurological injury or disease (e.g. Multiple Sclerosis, spinal cord injury)
☐ Documented endocrine abnormalities (i.e. low testosterone)
☐ Psychiatric disorder for which medication and/or treatment is being received
☐ Other
*Please specify:*_____

ADDITIONAL INFORMATION SPECIFIC TO DISEASE STATE
In addition to the above, the patient: ☐ Yes ☐ No Has received a prescription for any form of nitrates in the past 6 months. If yes, and your request is for Viagra, Cialis or Levitra, please document the circumstances in the space provided:

MEDICAL PRACTITIONER		PHARMACIST	
Name(Please Print)		Name(Please Print)	
Signature (If Applicable)	Date	Signature (If Applicable)	Date
Specialty		Store # and Location	
Phone #	Fax #	Phone #	

OFFICE USE ONLY		
Approval ☐ Accepted ☐ Declined Ph.C.:_____ Processing Number:	Date	Approved date range
	Quantity	Extension possible □ Yes □ No
	Notes	