USAble Administrators

Physician's Prior Authorization Questionnaire
Adcirca™

Patient: **ID#:** **DOB:**

Patient Address:

Adcirca™ is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. Adcirca™ (tadalafil) is only covered for select WHO Category I conditions. Please mark the patient's condition:

   - ☐ Idiopathic pulmonary arterial hypertension
   - ☐ Familial idiopathic pulmonary arterial hypertension
   - ☐ Pulmonary arterial hypertension associated with connective tissue disease (i.e. scleroderma, CRST, systemic lupus erythematosus)
   - ☐ Pulmonary arterial hypertension due to congenital systemic to pulmonary shunts (e.g. Eisenmenger syndrome)
   - ☐ Pulmonary arterial hypertension associated with AIDS
   - ☐ Pulmonary arterial hypertension associated with anorexigen use

2. Will the patient be using any other medications at the same time as tadalafil for the treatment of the pulmonary arterial hypertension? ☐ Yes ☐ No

   If Yes, please list: ____

   ____

Adcirca™ will be shipped to the patient from our Specialty Pharmacy.

______________________________ ______________________________

Physician's Signature Date

______________________________ ______________________________

Please **Print** Physician's Name & Specialty Phone Number / Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx