CONTRA COSTA HEALTH PLAN
A Division of Contra Costa Health Services

PRINT OR IMPRINT MEMBER INFORMATION

ERECTILE DYSFUNCTION MEDICATION
Questionnaire and Prior Authorization Form

Name:

Member ID#:

Phone #:

DOB:

PCP:

Please Print Legibly

Please Fax Request to the Appropriate Number:

☐ PERFORMRX PA GROUP: COMERCIAL PHARMACY WILL FILL PRESCRIPTION:
Customer Service Help Desk Operating Hours M-F 9:00 am - 9:00 PM,
Sat 9:00 am - 1:00 pm, except Holidays
FAX 1: 866-205-8014 Provider Service Help Desk phone number: 877-234-4269
FAX 2: 866-428-7369 *(URGENT REQUESTS ONLY*)
PA Group Operating Hours M-F 9:00 am - 6:00 pm, except Holidays

Medication Requested (Check One): Indicate strength:

☐ sildenafil (Viagra) _____ ☐ tadalafil (Cialis) _____ ☐ vardenafil (Levitra) _____
☐ alprostadil (Muse) ☐ alprostadil inj (Caverject)

The health plan requires submission of the following information for review of erectile dysfunction (ED) medication prior authorization requests:

1. Is the patient receiving medications reported to cause ED (examples listed below):

☐ No ☐ Yes (*please discontinue or provide justification*)

Drug Class	Examples*
Antidepressants	Amitriptyline (Elavil), Fluoxetine (Prozac)
Benzodiazepines	Diazepam (Valium), Lorazepam (Ativan)
Antihistamines	Diphenhydramine (Benadryl), Hydroxyzine (Vistaril)
Antihypertensives	Hydrochlorothiazide (Esidrix)
Opiates	Meperidine (Demerol), Oxycodone (OxyContin)
Miscellaneous	Cyclobenzaprine (Flexeril), Finasteride (Propecia, Proscar)

* This list is for reference only; please refer to prescribing information for all medications the patient is receiving.

2. Is the patient receiving medications known to interact with ED medications (examples listed below):

☐ No ☐ Yes *(PA will not be approved*)

Generic Name	Sample Brand Name*
Isosorbide dinitrate, mononitrate	Dilatrate, Dilatrate SR, Iso-Bid, Isordil, Imdur, Ismo, Monoket
Nitroglycerin	Deponit, Minitran, Nitro-Bid, Nitro-Dur, Nitrol Ointment
Ritonavir	Norvir
Amprenavir	Agenerase
Saquinavir	Invirase, Fortovase
Indinavir	Crixivan
Atazanavir	Reyataz
Fosamprenavir	Lexiva
Nelfinavir	Viracept
Doxazosin	Cardura
Prozosin	Minipress
Terazosin	Hytrin

* This list is for reference only; please refer to prescribing information for all medications the patient is receiving to rule out drug interactions.

3. ☐ examined and no evidence of testicular atrophy OR ☐ has recent normal free testosterone _____

4. ☐ over age 40 OR ☐ has para or quadriplegia **Comments:** _____

Prescriber Name: _____
(Please remember to submit requested consult note and lab results above.)

For Perform Rx or CCHP USE ONLY

☐ Approved ☐ Denied ☐ Deferred for Additional Information ☐ Approved as Modified ☐ Pt. Not Eligible

COMMENTS: _____

Authorizing Signature _____

Effective Date: _____ Expiration Date: _____