145 The West Mall, P.O. Box 110 U
Toronto, ON M8Z 5M4

PRIOR AUTHORIZATION PROGRAM FORM

Erectile Dysfunction – Viagra® (Sildenafil), Cialis® (Tadalafil), Levitra® (Vardenafil)

Instructions:

1. Section 1 to be completed by Plan Member/ Patient
2. Section 2 to be completed by Physician/ Pharmacist (expenses incurred by the completion of this form is at plan member's expense)
3. Section 3 to be completed by Pharmacist.
4. Please fax completed form to Formulary Management at 647-722-3054 (Toronto Area) / (Toll Free Fax) 1-877-639-4369 or Mail to 145 The West Mall P.O. Box 110 U, Toronto, Ontario, M8Z 5M4

Section 1: Patient Information

Cardholder's Name: (Last , First)	Certificate Number:	
Patient's Name: (Last, First)	Patient's Date of Birth (dd/mm/yy)	Relationship to Cardholder: Employee Spouse Dependent
Contact Information: : Number ( ) OR Patient / Legal Guardian Name: Number ( )		

Signature of Patient/ Legal Guardian: _____ Date (dd/mm/yy): _____

Section 2: Prescribed Drug Information

Drug Name:	Drug Strength:	Dosage Instructions:

Eligibility for drug coverage is determined if the patient meets at least one of the qualifying criteria listed below. In the case where the Patient has another drug plan; prior authorization may cover a portion that is not paid by the primary plan.
Please indicate if the patient meets at least one of the following qualifying criteria for drug coverage:

- ❑ For the treatment of organic erectile dysfunction resulting from: diabetes, vascular disease
- ❑ Neurologic damage (spinal cord, nerve damage or prostatectomy)
- ❑ Drug induced where it is inappropriate to discontinue causal drug (s)

Physician's Name: (Last, First)	License Number:
Address: (Street, City, Province, Postal Code)	Telephone Number : ( ) - Fax Number: ( ) -

Signature of Physician:_____ Date (dd/mm/yy): _____

Section 3: Pharmacist Information

Pharmacy Name:	Provider Number:
Pharmacy Address: (Street, City, Province, Postal Code)	Telephone Number : ( ) - Fax Number: ( ) -

Signature of Pharmacist: _____ Date (dd/mm/yy): _____

Pharmacist Name: (Print Last, First) _____

Internal Office Use Only:

Date Received:	DIN Number:	HICL:	Date Approved:
Effective Date:	Termination Date:	Approved: YES or NO	Approved by:
Notified: Pharmacy Member	Notification Date		