# Caverject® or Edex® (alprostadil) Prior Authorization Form

**Complete Patient and Physician information (PLEASE PRINT)**

STEP 1

| Member Name: | Physician Name: |
|---|---|
| Address: | Address: |
| | |
| Member ID: | Phone #: |
| Member DOB: | Fax #: |
| | Tax ID or NPI Number: |

**If Applicable:** Pharmacy Name: _____
Pharmacy Phone: _____

**Complete the Clinical Assessment:**

| | |
|---|---|
| Diagnosis | ☐ Patient being treated for erectile dysfunction resulting from surgical or radiation treatment of prostate cancer |
| | ☐ Other, please specify: |
| Supporting Documentation | Diagnosis: ICD-9 Code #/ Description / J Code (required): |
| | Please attach a copy of the prescription or provide ALL of the information below:<br>☐ Caverject ® ☐ Edex ® (alprostadil)<br>Strength _____<br>Sig _____<br>Qty _____<br>Refills _____ |
| | Please attach all relevant medical records and test results.<br>**Incomplete forms will not be processed.** |

STEP 3

**I certify that the above is correct and accurate to the best of my knowledge (please sign and date).**

_____ _____
Prescriber Signature Date

STEP 4

**Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:**

**970-248-5034**

Name of Person filling out form: _____

Pharmacy Technician initials _____ Date Initiated _____

**Confidentiality Notice:**

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