Prime THERAPEUTICS™

New Hampshire Medicaid Fee-for-Service Program Benign Prostatic Hyperplasia (BPH) Medication Criteria

Approval Date: November 21, 2024

Medications

Brand Name	Generic Name	Dosage Strengths
Cialis®	tadalafil	5 mg (the only approved dose for BPH)
Entadfi™	finasteride and tadalafil	5 mg/5 mg

Criteria for Approval

1. Diagnosis of Benign Prostatic Hyperplasia (BPH); **AND**
2. Failure of an alpha blocker; **AND**
3. Failure of an androgen hormone inhibitor.

Criteria for Denial

1. Criteria for approval not met; **OR**
2. Concurrent nitrate, alpha blocker, Revatio® or Adcirca® therapy, guanylate cyclase (GC) stimulators; **OR**
3. Request is for a female patient.
4. Use for erectile dysfunction.

Length of Authorization: 1 year

References

Available upon request.

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Revision History

Reviewed by	Reason for Review	Date
DUR Board	New	06/18/2012
Commissioner	Approval	07/10/2012
DUR Board	Revision	03/20/2017
Commissioner	Approval	06/08/2017
DUR Board	Revision	06/08/2021
Commissioner Designee	Approval	08/13/2021
DUR Board	Revision	12/13/2022
Commissioner Designee	Approval	01/26/2023
DUR Board	Revision	06/19/2023
Commissioner Designee	Approval	06/29/2023
DUR Board	Revision	10/15/2024
Commissioner Designee	Approval	11/21/2024

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