PRIOR AUTHORIZATION POLICY

POLICY: Erectile Dysfunction – Avanafil Prior Authorization Policy
- Stendra™ (avanafil tablets – Mist Pharmaceuticals, generic)

REVIEW DATE: 11/06/2024

OVERVIEW
Avanafil (Stendra, generic), a phosphodiesterase type 5 (PDE5) inhibitor, is indicated for the treatment of **erectile dysfunction**.[1]

POLICY STATEMENT
Prior Authorization is recommended for prescription benefit coverage of Avanafil. All approvals are provided for the duration noted below.

Automation: When available, the ICD-10 codes for male erectile dysfunction (ICD-10: N52.*) will be used for automation to allow approval of the requested medication. This automation is gender-selective and is not applicable for women; approval for use in women is always determined by prior authorization criteria.

RECOMMENDED AUTHORIZATION CRITERIA
Coverage of Avanafil is recommended in those who meet the following criteria:

FDA-Approved Indications

1. **Erectile Dysfunction**. Approve for 1 year.

CONDITIONS NOT RECOMMENDED FOR APPROVAL
Avanafil is not recommended in the following situations:

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES
1. Stendra™ tablets [prescribing information]. Cranford, NJ: Mist Pharmaceuticals; October 2022.