

## PRIOR AUTHORIZATION POLICY

**POLICY:** Erectile Dysfunction – Stendra Prior Authorization Policy

- Stendra™ (avanafil tablets – Mist Pharmaceuticals)

**REVIEW DATE:** 10/12/2022

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### OVERVIEW

Stendra is a phosphodiesterase type 5 (PDE5) inhibitor indicated for the treatment of **erectile dysfunction**.<sup>1</sup>

### POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Stendra. 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 Stendra is recommended in those who meet the following criteria:

#### FDA-Approved Indications

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

### CONDITIONS NOT RECOMMENDED FOR APPROVAL

Stendra 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; September 2019.