

## PULMONARY ARTERIAL HYPERTENSION AGENTS

### Prior Authorization

Adcirca, Letairis, Remodulin, sildenafil, Tracleer, Tyvaso, Ventavis

- Standard Request (72 hours)  
 Expedited Request (24 hours)

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.

### Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

### Medication Information

Drug Requested:	Strength:	Directions:
Quantity Dispensed:	Day Supply:	<input type="checkbox"/> Generic <input type="checkbox"/> Brand Necessary
<i>Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.</i>		
<input type="checkbox"/> New medication <input type="checkbox"/> Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.

### Billing Information

<input type="checkbox"/> Billed by <b>PHARMACY</b> dispensed to the member or provider for administration.	<input type="checkbox"/> Billed under <b>MEDICAL</b> benefit by provider. J CODE: _____ ICD-10 Code: _____	Place of Administration: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital/Clinic <input type="checkbox"/> Patient Home
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### Clinical Information

Diagnosis:	Date Diagnosed:
<p>Please attach <b><u>chart documentation</u></b> of right heart catheterization confirming diagnosis of pulmonary arterial hypertension. The following hemodynamic values must be included:</p> <p><input type="checkbox"/> Mean pulmonary arterial pressure (mPAP) <math>\geq</math> 25 mmHg</p> <p><input type="checkbox"/> Pulmonary capillary wedge pressure (PCWP) OR left atrial pressure OR left ventricular end-diastolic pressure (LVEDP) <math>\leq</math> 15 mmHg</p> <p><input type="checkbox"/> Pulmonary vascular resistance (PVR) <math>&gt;</math> 3 Wood units</p> <p><input type="checkbox"/> Documentation not available</p>	
<p>Please specify WHO Etiologic Classification of Pulmonary Hypertension:</p> <p><input type="checkbox"/> Group 1   <input type="checkbox"/> Group 2   <input type="checkbox"/> Group 3   <input type="checkbox"/> Group 4   <input type="checkbox"/> Group 5</p>	

Please indicate WHO functional class symptoms:    Class I       Class II       Class III       Class IV

Will the requested medication be used as monotherapy or combination therapy?    Monotherapy  
 Combination (Medication Name, Strength, Frequency): \_\_\_\_\_

<input type="checkbox"/> Sildenafil <input type="checkbox"/> Adcirca	Is the member currently taking a nitrate product? <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</span> For Adcirca requests, has the patient tried and failed sildenafil (Revatio)? <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</span>  *For sildenafil suspension requests, please include rationale of why sildenafil tablet cannot be utilized.	
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<input type="checkbox"/> Letairis	If the member is a woman of childbearing potential, has she had a baseline negative pregnancy test prior to initiation of therapy? <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No <input type="checkbox"/> Not applicable</span>	
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<input type="checkbox"/> Tracleer	Has the member previously tried Letairis? <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</span> Please provide dates of therapy: _____ Please provide reason for discontinuation: _____  Is the member currently taking glyburide or cyclosporine? <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</span> Has the member had baseline liver function tests prior to initiation of therapy? <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</span>  If the member is a woman of childbearing potential, has she had a baseline negative pregnancy test prior to initiation of therapy? <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No <input type="checkbox"/> Not applicable</span>	
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**Please provide any additional information which should be considered in the space below:**


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