PRIOR AUTHORIZATION REQUEST
Pulmonary Hypertension Agents

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. Is this a request for INITIAL or CONTINUATION of therapy with the requested medication?
   - ☐ INITIAL - **please proceed to question 2**
   - ☐ CONTINUATON - **please answer question 28 only**
2. ☐ Yes ☐ No Is this medication being prescribed by, or in consultation with a pulmonologist or cardiologist with experience in treating pulmonary hypertension?
3. What is the diagnosis or indication?
   - ☐ Pulmonary hypertension
   - ☐ All other indications or diagnoses (Please specify):_____
4. ☐ Yes ☐ No Does the patient have a mean pulmonary artery pressure (MPAP) GREATER THAN 25mmHg at rest, as confirmed by right-heart catheterization (RHC)?
5. ☐ Yes ☐ No Does the patient have fluid retention?
6. ☐ Yes ☐ No Is the patient receiving a diuretic?
7. What is the patient's pulmonary hypertension type?
   - ☐ Type I Pulmonary ARTERIAL Hypertension (PAH) - **please proceed to question 8-11 & 17**
   - ☐ Type II Pulmonary Hypertension due to left heart disease
   - ☐ Type III Pulmonary Hypertension due to lung disease and/or hypoxia - **please proceed to question 12,13 & 17**
   - ☐ Type IV Pulmonary Hypertension [chronic thromboembolic pulmonary hypertension (CTEPH)] - **please proceed to question 14-17**
   - ☐ Type V Pulmonary Hypertension due to unclear multifactorial mechanisms
8. ☐ Yes ☐ No Is the patient receiving anticoagulation?
9. ☐ Yes ☐ No Does the patient remain symptomatic despite optimal treatment with a calcium channel blocker?
10. ☐ Yes ☐ No Has the patient had a negative vasoreactivity test?

If you have any questions, call: 800-753-2851

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11. □ Yes □ No Is the patient's condition associated with connective tissue disease, congenital heart disease, HIV, portal hypertension, or schistosomiasis (this type is rarely vasoreactive)?
12. □ Yes □ No Does the patient remain WHO Class III to IV despite optimal treatment of underlying cause (such as COPD, interstitial lung disease, sleep-disordered breathing)?
13. □ Yes □ No Is the patient receiving supplemental oxygen?
14. □ Yes □ No Is the patient a surgical candidate?
15. □ Yes □ No Does the patient have persistent disease following thromboendarterectomy?
16. □ Yes □ No Is the patient receiving anticoagulation?
17. What is the requested medication?
    - □ Adcirca - **please answer questions 20-22,24 & 26**
    - □ Adempas - **please answer questions 19,23,24 & 26**
    - □ Letairis - **please answer questions 17,22,23 & 26**
    - □ Opsumit - **please answer questions 22,23,25 & 26**
    - □ Sidenafil - **please answer questions 22,24 & 26**
    - □ Tracleer - **please answer questions 18,22,23 & 26**
18. □ Yes □ No Does the patient have idiopathic pulmonary fibrosis?
19. □ Yes □ No Is the patient currently taking glyburide or cyclosporine?
20. □ Yes □ No Is the patient currently taking PDE inhibitors (such as sildenafil, Adcirca, dipyridamole, or theophylline)?
21. □ Yes □ No Has the patient tried and failed, or does the patient have a contraindication or intolerance to, an adequate one-month trial of sildenafil?
22. □ Yes □ No Is the patient currently taking a guanylate cyclase stimulator (such as Adempas)?
23. □ Yes □ No Does the patient have pulmonary veno-occlusive disease (PVOD)?
24. □ Yes □ No Is the patient pregnant?
25. □ Yes □ No Is this medication being prescribed in combination with organic nitrates (such as isosorbide mononitrate, isosorbide dinitrate, or nitroglycerin)?
26. □ Yes □ No Is this medication being prescribed in combination with strong CYP3A4 inducers/inhibitors?
27. □ Yes □ No Does the patient have World Health Organization (WHO) Class II to IV symptoms [such as fatigue, dizziness, and fainting (near syncope)]?
28. □ Yes □ No Has the patient responded to therapy with the requested medication?

Please document the diagnoses, symptoms, and/or any other information important to this review:

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SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

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