PRIOR AUTHORIZATION REQUEST
Remodulin

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. What is the indication or diagnosis?
   - ☐ Pulmonary arterial hypertension [PAH] (WHO Group 1) - **Please answer questions 2 - 17**
   - ☐ Chronic thromboembolic pulmonary hypertension (CTEPH) - **Please answer question 3**
   - ☐ Chronic obstructive pulmonary disease (COPD) in a patient without PAH (WHO Group 1).
   - ☐ All other indications or diagnosis - Please specify ____________________________________
2. ☐ Yes ☐ No Does the patient have WHO Group 1 PAH?
3. ☐ Yes ☐ No Is the medication being prescribed by, or in consultation with, a cardiologist or a pulmonologist?
4. ☐ Yes ☐ No Is the patient currently receiving the requested medication?
5. ☐ Yes ☐ No Is documentation being provided to confirm that the patient has had a right heart catheterization?
6. ☐ Yes ☐ No Did the results of the right heart catheterization confirm the diagnosis of WHO Group 1 PAH?
7. ☐ Yes ☐ No Has the patient had a right heart catheterization?
8. ☐ Yes ☐ No Is the patient in Class III or IV of the WHO classification of functional status?
9. ☐ Yes ☐ No Is the patient in Class II of the WHO classification of functional status?
10. ☐ Yes ☐ No Has the patient tried or is the patient currently receiving one oral agent for PAH?
11. ☐ Yes ☐ No Has the patient tried one inhaled or parenteral prostacyclin product for PAH?
12. ☐ Yes ☐ No Does the patient have idiopathic PAH?
13. ☐ Yes ☐ No Has the patient tried one calcium channel blocker (CCB) therapy?
14. ☐ Yes ☐ No Is the patient unable to take calcium channel blocker therapy?
15. ☐ Yes ☐ No Did the patient have vasodilator testing?
16. ☐ Yes ☐ No Is the patient unable to undergo a vasodilator test according to the prescriber?
17. ☐ Yes ☐ No Has the patient had an acute response to vasodilator testing that occurred during the right heart catheterization according to the prescriber?

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

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SECTION B Physician Signature

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PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

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