PRIOR AUTHORIZATION REQUEST
Revatio

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

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

Medication Requested: Revatio **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 answer questions 2-17**
   - ☐ CONTINUATON - **please answer question 18**
2. ☐ Yes ☐ No Is this medication being prescribed by, or in consultation with a pulmonologist or cardiologist with experience in treating pulmonary hypertension?
3. ☐ Yes ☐ No Does the patient have a mean pulmonary artery pressure (MPAP) GREATER THAN 25mmHg at rest, as confirmed by right-heart catheterization (RHC)?
4. ☐ Yes ☐ No Does the patient have fluid retention?
5. ☐ Yes ☐ No Is the patient receiving a diuretic?
6. What is the patient's pulmonary hypertension type?
   - ☐ Type I Pulmonary ARTERIAL Hypertension (PAH) - **please answer questions 7-10 & 15-17**
   - ☐ Type II Pulmonary Hypertension due to left heart disease
   - ☐ Type III Pulmonary Hypertension due to lung disease and/or hypoxia
     - **please answer questions 11,12 & 15-17**
   - ☐ Type IV Pulmonary Hypertension [chronic thromboembolic pulmonary hypertension (CTEPH)]
     - **please answer questions 7 & 13-17**
   - ☐ Type V Pulmonary Hypertension due to unclear multifactorial mechanisms
7. ☐ Yes ☐ No Is the patient receiving anticoagulation?
8. ☐ Yes ☐ No Does the patient remain symptomatic despite optimal treatment with a calcium channel blocker?
9. ☐ Yes ☐ No Has the patient had a negative vasoreactivity test?
10. ☐ 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)?
11. ☐ Yes ☐ No Does the patient remain WHO Class III to IV despite optimal treatment of underlying

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cause (such as COPD, interstitial lung disease, sleep-disordered breathing)?

12. ☐ Yes ☐ No Is the patient receiving supplemental oxygen?
13. ☐ Yes ☐ No Is the patient a surgical candidate?
14. ☐ Yes ☐ No Does the patient have persistent disease following thromboendarterectomy?
15. ☐ Yes ☐ No Is this medication being prescribed in combination with organic nitrates (such as isosorbide mononitrate, isosorbide dinitrate, or nitroglycerin)?
16. ☐ Yes ☐ No Does the patient have pulmonary veno-occlusive disease (PVOD)?
17. ☐ Yes ☐ No Does the patient have World Health Organization (WHO) Class II to IV symptoms [such as fatigue, dizziness, and fainting (near syncope)]?
18. ☐ 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:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

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