maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST
Veletri

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 17**
   - ☐ 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 patient currently receiving the requested medication?
4. ☐ Yes ☐ No Is documentation being provided to confirm that the patient has had a right heart catheterization?
5. ☐ Yes ☐ No Did the results of the right heart catheterization confirm the diagnosis of WHO Group 1 PAH?
6. ☐ Yes ☐ No Has the patient had a right heart catheterization?
7. ☐ Yes ☐ No Is the patient in Class III or IV of the WHO classification of functional status?
8. ☐ Yes ☐ No Is the patient in Class II of the WHO classification of functional status?
9. ☐ Yes ☐ No Has the patient tried or is the patient currently receiving one oral agent for PAH?
10. ☐ Yes ☐ No Has the patient tried one inhaled or parenteral prostacyclin product for PAH?
11. ☐ Yes ☐ No Does the patient have idiopathic PAH?
12. ☐ Yes ☐ No Has the patient tried one calcium channel blocker (CCB) therapy?
13. ☐ Yes ☐ No Is the patient unable to take calcium channel blocker therapy? Note: examples of reasons a patient cannot take calcium channel blocker therapy include right heart failure or decreased cardiac output.
14. ☐ Yes ☐ No Did the patient have vasodilator testing?
15. ☐ Yes ☐ No Is the patient unable to undergo a vasodilator test according to the prescriber?
16. ☐ Yes ☐ No Has the patient had an acute response to vasodilator testing that occurred during the right heart catheterization according to the prescriber?

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

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17. ☐ Yes ☐ No Is the medication being prescribed by, or in consultation with, a cardiologist or a pulmonologist?

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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