maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Uptravi

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

1	What is the diagnosis or indication? [] Pulmonary arterial hypertension (PAH) World Health Organization (WHO) Group 1 (If checked, go to 2) [] Other (If checked, no further questions)		
2	Does the patient have WHO Group 1 PAH? [If no, no further questions.]	Yes	No
3	Is the medication being prescribed by, or in consultation with, a cardiologist or a pulmonologist? [If no, no further questions.]	Yes	No

If you have any questions, call:
1-888-258-8250

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4	Is the patient currently receiving the requested medication? [If yes, skip to question 7.]	Yes	No
5	Is documentation provided to confirm that the patient has had a right heart catheterization? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
6	Did the results of the right heart catheterization confirm the diagnosis of WHO Group 1 PAH? [If yes, skip to question 9.] [If no, no further questions.]	Yes	No
7	Has the patient had a right heart catheterization? [If no, no further questions.]	Yes	No
8	Did the results of the right heart catheterization confirm the diagnosis of WHO Group 1 PAH? [No further questions.]	Yes	No
9	Has the patient tried at least one oral medication for PAH from one of the three following different categories (either alone or in combination) for greater than or equal to 60 days: one phosphodiesterase type 5 (PDE5) inhibitor, one endothelin receptor antagonist (ERA), or Adempas (riociguat tablets)? [NOTE: Examples of PDE5 inhibitors include Revatio (sildenafil tablets and suspension), Adcirca (tadalafil tablets), and Alyq (tadalafil tablets), and examples of ERAs include Tracleer (bosentan tablets), Letairis (ambrisentan tablets), and Opsumit (macitentan tablets). [If yes, no further questions.]	Yes	No
10	Is the patient receiving, or has a history of, one prostacyclin therapy for PAH? [NOTE: Examples of prostacyclin therapies for PAH include Orenitram (treprostinil tablets), Tyvaso (treprostinil inhalation solution), Ventavis (iloprost inhalation solution), Remodulin (treprostinil injection), and epoprostenol injection (Flolan, Veletri).]	Yes	No

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: 1-833-896-0656

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 authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

If you have any questions, call: 1-888-258-8250