maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Veletri

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 indication or diagnosis?

[] Pulmonary arterial hypertension (PAH) (World Health Organization (WHO) Group 1) (If checked, go to 2)

[] Chronic thromboembolic pulmonary hypertension (CTEPH) (If checked, go to 18)

[] Chronic obstructive pulmonary disease (COPD) in a patient without pulmonary arterial hypertension (PAH) (World Health Organization (WHO) Group 1) (If checked, no further questions)

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

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	[] Other (If checked, no further questions)		
2	Is the medication being prescribed by, or in consultation with, a cardiologist or a pulmonologist? [If no, no further questions.]	Yes	No
3	Is the patient currently receiving the requested medication? [If no, skip to question 6.]	Yes	No
4	Has the patient had a right heart catheterization? [If no, no further questions.]	Yes	No
5	Did the results of the right heart catheterization confirm the diagnosis of World Health Organization (WHO) Group 1 pulmonary arterial hypertension (PAH)? [No further questions.]	Yes	No
6	Is documentation being provided to confirm that the patient has had a right heart catheterization? ACTION REQUIRED: Submit supporting documentation. [NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Documentation may include, but is not limited to, chart notes and catheterization laboratory reports. For a patient case in which the documentation requirement of the right heart catheterization upon prior authorization coverage review for a different medication indicated for World Health Organization (WHO) Group 1 pulmonary arterial hypertension (PAH) has been previously provided, the documentation requirement in this Pulmonary Arterial Hypertension - Epoprostenol injection Prior Authorization Policy is considered to be met.] [If no, no further questions.]	Yes	No
7	Did the results of the right heart catheterization confirm the diagnosis of World Health Organization (WHO) Group 1 pulmonary arterial hypertension (PAH)? [If no, no further questions.]	Yes	No
8	Is the patient in Class III or IV of the World Health Organization (WHO) classification of functional status? [If yes, skip to question 12.]	Yes	No
9	Is the patient in Class II of the World Health Organization (WHO) classification of functional status? [If no, no further questions.]	Yes	No
10	Has the patient tried or is the patient currently receiving one oral agent for pulmonary arterial hypertension (PAH)? [NOTE: Examples of oral agents for pulmonary arterial hypertension (PAH) include Tracleer (bosentan tablets), Letairis (ambrisentan tablets [generic]), Opsumit (macitentan tablets), Adempas (riociguat tablets), Revatio (sildenafil tablets, oral suspension), Adcirca (tadalafil tablets), Orenitram (treprostinil extended-release	Yes	No

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	tablets), Alyq (tadalafil tablets), and Uptravi (selexipag tablets).] [If yes, skip to question 12.]		
11	Has the patient tried one inhaled or parenteral prostacyclin product for pulmonary arterial hypertension (PAH)? [NOTE: Examples of inhaled and parenteral prostacyclin products for pulmonary arterial hypertension (PAH) include Remodulin (treprostinil injection [generic]), Ventavis (iloprost inhalation solution), and Tyvaso (treprostinil inhalation solution).] [If no, no further questions.]	Yes	No
12	Does the patient have idiopathic pulmonary arterial hypertension (PAH)? [If no, no further questions.]	Yes	No
13	Has the patient tried one calcium channel blocker (CCB) therapy? [NOTE: Examples of channel blockers (CCBs) include amlodipine, nifedipine extended-release tablets.] [If yes, no further questions.]	Yes	No
14	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.] [If yes, no further questions.]	Yes	No
15	Did the patient have vasodilator testing? [If yes, skip to question 17.]	Yes	No
16	Is the patient unable to undergo a vasodilator test according to the prescriber? [No further questions.]	Yes	No
17	Has the patient had an acute response to vasodilator testing that occurred during the right heart catheterization according to the prescriber? [NOTE: An example of a response can be defined as a decrease in mean pulmonary arterial pressure (mPAP) of at least 10 mm Hg to an absolute mean pulmonary arterial pressure (mPAP) of less than 40 mm Hg without a decrease in cardiac output.] [No further questions.]	Yes	No
18	Is the medication being prescribed by, or in consultation with, a cardiologist or a pulmonologist?	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.

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