maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Ventavis/Tyvaso

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	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
2	Is the requested medication being prescribed by, or in consultation with, a cardiologist or a pulmonologist? [If no, no further questions.]	Yes	No
3	Will the requested medication dose exceed FDA approved dosing for the indication? [If yes, no further questions.]	Yes	No
4	Will the requested medication be used concurrently with an oral or parenteral	Yes	No

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

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	prostacyclin agent? [NOTE: Examples of medications include Orenitram (treprostinil extended-release tablets), Uptravi (selexipag tablets and intravenous infusion), epoprostenol intravenous infusion, and treprostinil subcutaneous or intravenous infusion.] [If yes, no further questions.]		
5	Is this request for initial therapy or for a continuation of therapy? [] Initial (If checked, go to 9) [] Continuation (If checked, go to 6)		
6	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 9.]	Yes	No
7	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If yes, skip to question 18.]	Yes	No
8	Does the patient have a documented clinically significant response, as determined by the provider? [If no, no further questions.]	Yes	No
9	What is the indication or diagnosis? [] Pulmonary arterial hypertension (WHO Group 1 PAH) (If checked, go to 10) [] Pulmonary arterial hypertension (WHO Group 3 PAH) (If checked, go to 14) [] Other (If checked, no further questions.)		
10	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
11	Did the results of the right heart catheterization confirm the diagnosis of WHO Group 1 PAH? [If no, no further questions.]	Yes	No
12	Is the patient in Class III or IV of the WHO classification of functional status? [If no, no further questions.]	Yes	No
13	Does the patient have a trial and failure, intolerance, or contraindication to TWO oral agents for PAH? [NOTE: Examples of oral agents for PAH include Tracleer (bosentan tablets), Letairis (ambrisentan tablets), Opsumit (macitentan tablets), Revatio (sildenafil tablets and suspension), Adcirca (tadalafil tablets), Alyq (tadalafil tablets),	Yes	No

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	Adempas (riociguat tablets), Orenitram (treprostinil extended-release tablets), and Uptravi (selexipag tablets).] [No further questions.]		
14	Is documentation provided to confirm that the patient has had a right heart catheterization to confirm the diagnosis of WHO Group 3 PAH? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	Does the patient have a baseline forced vital capacity of LESS THAN 70%? [If no, no further questions.]	Yes	No
16	Does the patient have documentation of diffused parenchymal lung disease on computed tomography of the chest? [If no, no further questions.]	Yes	No
17	What drug is being requested? [] Ventavis (If checked, no further questions.) [] Tyvaso, Tyvaso starter kit, Tyvaso refill kit (If checked, no further questions.)		
18	What is the indication or diagnosis? [] Pulmonary arterial hypertension (WHO Group 1 PAH) (If checked, go to 19) [] Pulmonary arterial hypertension (WHO Group 3 PAH) (If checked, go to 19) [] Other (If checked, no further questions.)		
19	Does the patient have a documented clinically significant response to therapy according to the prescriber?	Yes	No

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

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

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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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