PRIOR AUTHORIZATION REQUEST

Pulmonary Hypertension Agents

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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is this request for initial therapy or for continuation of therapy? [] Initial (If checked, go to 2) [] Continuation (If checked, go to 30)		
2	Is this medication being prescribed by, or in consultation with a pulmonologist or cardiologist with experience in treating pulmonary hypertension? [If no, no further questions.]	Yes	No
3	What is the diagnosis or indication?		

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	[] Pulmonary hypertension (If checked, go to 4) [] Other (If checked, no further questions)		
4	Does the patient have a mean pulmonary artery pressure (MPAP) GREATER THAN 25mmHg at rest as confirmed by right-heart catheterization (RHC)? [If no, no further questions.]	Yes	No
5	Does the patient have fluid retention? [If no, skip to question 7.]	Yes	No
6	Is the patient receiving a diuretic? [If no, no further questions.]	Yes	No
7	What is the patient's pulmonary hypertension type? [] Type I Pulmonary ARTERIAL Hypertension (PAH) (If checked, go to 8) [] Type II Pulmonary Hypertension due to left heart disease (If checked, no further questions) [] Type III Pulmonary Hypertension due to lung disease and/or hypoxia (If checked, go to 11) [] Type IV Pulmonary Hypertension [chronic thromboembolic pulmonary hypertension (CTEPH)] (If checked, go to 13) [] Type V Pulmonary Hypertension due to unclear multifactorial mechanisms (If checked, no further questions)		
8	Does the patient remain symptomatic despite optimal treatment with a calcium channel blocker? [If yes, skip to question 16.]	Yes	No
9	Has the patient had a negative vasoreactivity test? [If yes, skip to question 16.]	Yes	No
10	Is the patient's condition associated with connective tissue disease, congenital heart disease, HIV, portal hypertension, or schistosomiasis (this type is rarely vasoreactive)? [If yes, skip to question 16.] [If no, no further questions.]	Yes	No
11	Does the patient remain WHO Class III to IV despite optimal treatment of underlying causes (such as COPD, interstitial lung disease, sleep-disordered breathing)? [If no, no further questions.]	Yes	No
12	Is the patient receiving supplemental oxygen? [If yes, skip to question 16.]	Yes	No

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[If no, no further questions.]

13	Has the patient had surgery (thromboendarterectomy)? [If no, skip to question 15.]	Yes	No
14	Does the patient have persistent disease following thromboendarterectomy? [If no, no further questions.]	Yes	No
15	Is the patient receiving anticoagulation? [If no, no further questions.]	Yes	No

16 What is the requested medication?

[] Adcirca, Alyq, tadalafil, or Tadliq (If checked, go to 20)

[] Adempas (If checked, go to 19)

[] Letairis or ambrisentan (If checked, go to 17)

[] Opsumit (If checked, go to 25)

[] sildenafil, Revatio, or Liqrev (If checked, go to 27)

[] Tracleer or bosentan (If checked, go to 18)

17	Does the patient have idiopathic pulmonary fibrosis? [If yes, no further questions.] [If no, skip to question 26.]	Yes	No
18	Is the patient currently taking glyburide or cyclosporine? [If yes, no further questions.] [If no, skip to question 26.]	Yes	No
19	Is the patient currently taking PDE inhibitors (such as sildenafil, Adcirca, dipyridamole, or theophylline)? [If yes, no further questions.] [If no, skip to question 23.]	Yes	No
20	Has the patient tried and failed, or does the patient have a contraindication or intolerance to an adequate one-month trial of sildenafil? [If no, no further questions.]	Yes	No
21	Is the patient currently taking a guanylate cyclase stimulator (such as Adempas)? [If yes, no further questions.]	Yes	No
22	Does the patient have pulmonary veno-occlusive disease (PVOD)? [If yes, no further questions.] [If no, skip to question 24.]	Yes	No

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23	Is the patient pregnant? [If yes, no further questions.]	Yes	No
24	Is this medication being prescribed in combination with organic nitrates (such as isosorbide mononitrate, isosorbide dinitrate, or nitroglycerin)? [If yes, no further questions.] [If no, skip to question 29.]	Yes	No
25	Is this medication being prescribed in combination with strong CYP3A4 inducers/inhibitors? [If yes, no further questions.]	Yes	No
26	Is the patient pregnant? [If yes, no further questions.] [If no, skip to question 28.]	Yes	No
27	Is this medication being prescribed in combination with organic nitrates (such as isosorbide mononitrate, isosorbide dinitrate, or nitroglycerin)? [If yes, no further questions.]	Yes	No
28	Does the patient have pulmonary veno-occlusive disease (PVOD)? [If yes, no further questions.]	Yes	No
29	Does the patient have World Health Organization (WHO) Class II to IV symptoms such as fatigue, dizziness, and fainting (near syncope)? [No further questions.]	Yes	No
30	Is this medication being prescribed by, or in consultation with a pulmonologist or cardiologist with experience in treating pulmonary hypertension? [If no, no further questions.]	Yes	No
31	Has the patient responded to therapy with the requested medication?	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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