maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Remodulin

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 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 pulmonologist or cardiologist with experience treating pulmonary hypertension? [If no, no further questions.]	Yes	No
3	Is the patient currently receiving the requested medication? [If no, skip to question 8.]	Yes	No

PRIOR AUTHORIZATION REQUEST

4	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 no, skip to question 8.]	Yes	No
5	Has the patient been diagnosed with pulmonary arterial hypertension (PAH) as WHO Group 1? [If no, no further questions.]	Yes	No
6	Has the patient been established on therapy for at least 3 months? [If no, skip to question 9.]	Yes	No
7	Has documentation been submitted to confirm that the patient has experienced a clinically significant response, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
8	Has the patient been diagnosed with pulmonary arterial hypertension (PAH) as WHO Group 1? [If no, no further questions.]	Yes	No
9	Will the patient be treated concomitantly with organic nitrates (for example, isosorbide mononitrate, isosorbide dinitrate, nitroglycerin)? [If yes, no further questions.]	Yes	No
10	Does the patient have NYHA Class II, III or IV symptoms? [If no, no further questions.]	Yes	No
11	Has documentation been submitted to confirm that the patient has had a right-heart catheterization (RHC)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
12	Has documentation been submitted to confirm that the patient has a mean pulmonary artery pressure (mPAP) GREATER THAN 25 mmHg? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
13	Has documentation been submitted to confirm that the patient has been evaluated with a baseline 6-minute walk test? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
14	Has documentation been submitted to confirm that the patient has experienced treatment failure with oral calcium channel blockers? ACTION REQUIRED: Submit	Yes	No

PRIOR AUTHORIZATION REQUEST

	supporting documentation. [NOTE: Examples of calcium channel blockers include amlodipine, nifedipine extended-release tablets.] [If yes, no further questions.]		
15	Has documentation been submitted to confirm that the patient has a contraindication to oral calcium channel blockers? ACTION REQUIRED: Submit supporting documentation.	Yes	No

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: 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