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. 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 a continuation of therapy? [] Initial (If checked, go to 7) [] Continuation (If checked, go to 2)		
2	Is the patient currently receiving the requested medication? [If no, skip to question 7.]	Yes	No
3	Has the patient been receiving medication samples of the requested medication?	Yes	No

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	[If yes, skip to question 7.]		
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 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	What is the indication or diagnosis? [] Pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1) (If checked, go to 8) [] Chronic thromboembolic pulmonary hypertension (CTEPH) (If checked, go to 19) [] Chronic obstructive pulmonary disease (COPD) in a patient without pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1) (If checked, no further questions) [] Other (If checked, no further questions)		
8	Is documentation being provided to confirm that the patient has had a right heart catheterization? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
9	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
10	Is the patient in Class III or IV of the World Health Organization (WHO) classification of functional status? [If yes, skip to question 14.]	Yes	No
11	Is the patient in Class II of the World Health Organization (WHO) classification of functional status? [If no, no further questions.]	Yes	No
12	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 tablets), Alyq (tadalafil tablets), and Uptravi (selexipag tablets).]	Yes	No

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	[If yes, skip to question 14.]		
13	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
14	Does the patient have idiopathic pulmonary arterial hypertension (PAH)? [If no, skip to question 19.]	Yes	No
15	Has the patient been treated with at least one calcium channel blocker? [If yes, skip to question 19.]	Yes	No
16	Does the patient have a documented contraindication or intolerance to calcium channel blocker therapy? [If yes, skip to question 19.]	Yes	No
17	Is the patient unable to undergo a vasodilator test according to the prescriber? [If yes, skip to question 19.]	Yes	No
18	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.] [If yes, no further questions.]	Yes	No
19	Is the medication being prescribed by, or in consultation with, a cardiologist or a pulmonologist? [If no, no further questions.]	Yes	No
20	Does the requested dose exceed FDA approved label dosing for the requested indication? [NOTE: Dosing: Max dosage of 1600 mcg twice daily]	Yes	No

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

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

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

Version 06.2026

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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.

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

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