



PRIOR AUTHORIZATION REQUEST

UPTRAVI

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? | Yes | No |
| | [If no, skip to question 7.] | | |

If you have any
questions, call:
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3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 7.]	Yes	No
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 (stabilization of disease, improvement in 6 minute walk distance, the absence of worsening of WHO functional class)? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	What is the diagnosis or indication? ☐ Pulmonary arterial hypertension (PAH) World Health Organization (WHO) Group 1 (If checked, go to 8) ☐ Other (If checked, no further questions)		
8	Is the patient 18 years of age or greater? [If no, no further questions.]	Yes	No
9	Has the patient had a right heart catheterization? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
10	Did the results of the right heart catheterization confirm the diagnosis of WHO Group 1 PAH? [If no, no further questions.]	Yes	No
11	Has the patient tried at least one oral medication for PAH from one of the three following different categories (either alone or in combination) for greater than or equal to 60 days: one phosphodiesterase type 5 (PDE5) inhibitor, one endothelin receptor antagonist (ERA), or Adempas (riociguat tablets)? [NOTE: Examples of PDE5 inhibitors include Revatio (sildenafil tablets and suspension), Adcirca (tadalafil tablets), and Alyq (tadalafil tablets), and examples of ERAs include Tracleer (bosentan tablets), Letairis (ambrisentan tablets), and Opsumit (macitentan tablets).] [If yes, skip to question 13.]	Yes	No
12	Is the patient receiving, or has a history of, one inhaled or parenteral prostacyclin	Yes	No

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therapy for PAH?

[NOTE: Examples of prostacyclin therapies for PAH include Orenitram (treprostinil tablets), Tyvaso (treprostinil inhalation solution), Ventavis (iloprost inhalation solution), Remodulin (treprostinil injection), and epoprostenol injection (Flolan, Veletri).]

[If no, no further questions.]

- | | | | |
|----|---|-----|----|
| 13 | Is the medication being prescribed by, or in consultation with, a cardiologist or a pulmonologist?
[If no, no further questions.] | Yes | No |
| 14 | Does the requested dose exceed FDA approved label dosing for the requested indication?
Note: Dosing is 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

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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