Prior Authorization Request Form for Pulmonary Hypertension Agents

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
NPI:	Group #:
Office Contact Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)

Drug name and strength:	Dosage Interval (sig):	Qty. per Day:

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: _____

Does the member have a history of a contraindication to the requested medication?
☐ Yes
☐ No

Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Pulmonary Hypertension agents? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*
Does not apply to non-preferred brands when the therapeutically equivalent generic is preferred or to non-preferred generics when the therapeutically equivalent brand is preferred

Medications Previously Taken (start and end date and dose):
☐ Yes
☐ No
[redacted]

- ☐ Member has a current history (within past 90 days) of using the prescribed the requested non-preferred PAH agent, since:_____
- ☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information:_____

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

TREATMENT OF PULMONARY HYPERTNESION:

- ☐ Treatment of a diagnosis indicated in FDA-approved package labeling OR medically accepted indication, **excluding use to treat sexual or erectile dysfunction**
- ☐ Requested medication is appropriate based on current risk calculator (e.g., REVEAL 2.0) and current medical literature
- ☐ For members <18 years, if not prescribed by the following specialist, a pediatric pulmonologist, pediatric cardiologist, or heart and lung transplant specialist skilled in treating pulmonary hypertension, please indicate a specialist consulted:_____
- ☐ For members ≥ 18 years old, if not prescribed by a practitioner at a Pulmonary Hypertension Association-accredited center or an appropriate specialist pulmonologist, cardiologist or rheumatologist skilled in treating pulmonary hypertension, please indicate a specialist consulted:_____

- ☐ For a diagnosis of PAH (WHO Group 1), documentation of right heart catherization indicating the following hemodynamic values:
  - ☐ Mean pulmonary arterial pressure > 20mmHg
  - ☐ Pulmonary capillary wedge pressure, left arterial pressure, or left ventricular end-diastolic pressure ≤ 15mmHg
  - ☐ Pulmonary vascular resistance≥3 Wood units

TREATMENT OF IDIOPATHIC PULMONARY ARTERIAL HYPERTNESION:

- ☐ One of the following:
  - ☐ Has a H_2FPEF score < 2
  - ☐ Has a left atrial volume index < 35mL/m^2
  - ☐ Has a negative provocative test in a heart catheterization lab (fluid challenge with pulmonary capillary wedge pressure, left atrial pressure, or left ventricular end-diastolic pressure ≤17mmHg)
- ☐ One of the following:
  - ☐ Documentation of acute vasoreactivity testing
  - ☐ Has a contraindication to vasoreactivity testing or is at increased risk of adverse events during acute vasoreactivity (e.g., high risk stratification based on current risk calculator assessment (e.g., REVEAL 2.0), low systemic blood pressure, low cardiac index, or pulmonary veno-occusive disease)
- ☐ Member demonstrates acute vasoreactivity, has a documented history of therapeutic failure, contraindication or intolerance of calcium channel blocker (i.e. amlodipine, nifedipine or diltiazem)

TREATMENT OF CHRONIC THROMBOEMBOLIC PULMONARY HYPERTNESION (CTEPH):

- ☐ Documentation of right heart catherization indicating the following hemodynamic values:
  - ☐ Mean pulmonary arterial pressure > 20mmHg:_____
  - ☐ Pulmonary vascular resistance ≥ 3 Wood units:_____

RENEWAL REQUIEST:

- ☐ Member has demonstrated tolerability and a positive clinical response based on the prescriber's assessment:_____

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Pharmacy Department will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)