PULMONARY HYPERTENSION AGENTS, ORAL AND INHALED

PRIOR AUTHORIZATION FORM *(form effective 1/5/2026)*

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/

Prior authorization guidelines for **Pulmonary Hypertension Agents, Oral and Inhaled** and **Quantity Limits/Daily Dose Limits** are available on the PA Health & Wellness website at https://www.pahealthwellness.com/providers/pharmacy.html.

☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Member name:		City/state/zip:	
Member ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug name:	Strength:	Formulation:	
Dose/directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	
Has the member been using the requested medication within the past 90 days?		☐Yes ☐No	*Submit documentation of drug regimen and clinical response.*
Is the requested medication prescribed by or in consultation with a practitioner at a Pulmonary Hypertension Association-accredited center or other specialist skilled in treating pulmonary hypertension (i.e., pediatric or adult pulmonologist or cardiologist, rheumatologist)?		☐Yes ☐No	*Submit documentation of consultation, if applicable.*

Complete all sections that apply to the member and this request.

Check all that apply and submit documentation for each item.

INITIAL requests

1. For treatment of PULMONARY ARTERIAL HYPERTENSION (PAH) (WHO GROUP 1):

☐Had a right heart catheterization showing ALL of the following hemodynamic values:
- ☐Mean pulmonary arterial pressure ≥25 mmHg
- ☐Pulmonary capillary wedge pressure, left atrial pressure, or left ventricular end-diastolic pressure ≤15 mmHg
- ☐Pulmonary vascular resistance >3 Wood units

☐**Also, for IDIOPATHIC or HERITABLE PAH:**
- ☐Has chart documentation of acute vasoreactivity testing
- ☐ONE of the following:
  - ☐Has a contraindication to vasoreactivity testing

☐ Is at increased risk of adverse events during acute vasoreactivity testing (e.g., presence of severe [functional class IV] symptoms, low systemic blood pressure, low cardiac index, pulmonary veno-occlusive disease)

☐ **For a member with idiopathic or heritable PAH who demonstrates acute vasoreactivity:**

☐ Has a history of trial and failure of or contraindication or intolerance to calcium channel blockers (i.e., amlodipine, diltiazem, nifedipine)

2. For treatment of CHRONIC THROMBOEMBOLIC PULMONARY HYPERTENSION (CTEPH):

☐ Had a right heart catheterization showing BOTH of the following hemodynamic values:

☐ Mean pulmonary arterial pressure ≥25 mmHg

☐ Pulmonary vascular resistance >3 Wood units

3. For treatment of PULMONARY HYPERTENSION associated with INTERSTITIAL LUNG DISEASE (PH-ILD) (WHO GROUP 3):

☐ Had a right heart catheterization showing ALL of the following hemodynamic values:

☐ Mean pulmonary arterial pressure ≥25 mmHg

☐ Pulmonary capillary wedge pressure ≤15 mmHg

☐ Pulmonary vascular resistance >3 Wood units

☐ Had recent CT imaging demonstrating interstitial lung disease

4. For a NON-PREFERRED Pulmonary Hypertension Agent, Oral and Inhaled:

☐ Tried and failed or has a contraindication or an intolerance to the preferred Pulmonary Hypertension Agents, Oral and Inhaled *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

RENEWAL requests	
Does the member continue to benefit from the requested medication?	☐ Yes ☐ No *Submit documentation of clinical response.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 844-205-3386

Prescriber 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.)