

# PULMONARY ARTERIAL HYPERTENSION (PAH) PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

**Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.**

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit [www.myprime.com](http://www.myprime.com). Start saving time today by filling out this form electronically. Visit [covermymeds.com](http://covermymeds.com) to begin using this free service.

**What is the priority level of this request?**

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

**Today's Date:** \_\_\_\_\_

**PATIENT AND INSURANCE INFORMATION**

**Date of Service (if differs from Today's Date):** \_\_\_\_\_

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

**PRESCRIBER/CLINIC INFORMATION**

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

**PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST**

Patient Diagnosis: <input type="checkbox"/> Chronic thromboembolic pulmonary hypertension (CTEPH), WHO Group 4 <input type="checkbox"/> Pulmonary Arterial Hypertension (PAH), WHO Group 1 <input type="checkbox"/> Pulmonary hypertension associated with interstitial lung disease (PH-ILD, WHO group 3) <input type="checkbox"/> Raynaud's Phenomenon <input type="checkbox"/> Other, ICD code plus description: _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
<b>For all requests:</b> 1. Is the patient currently being treated with the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient currently stable on the requested agent? <b>Please note, chart notes are required.</b> ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Has the patient been treated with the requested agent within the past 90 days (starting on samples is not approvable)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient at risk if therapy is changed?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify risk: _____ _____	
3. Does the patient have any FDA labeled contraindications to the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify FDA labeled contraindications: _____ _____	
4. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., cardiologist, pulmonologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Will the patient be using the requested agent in combination with a PDE5 inhibitor [e.g., tadalafil (Adcirca or Cialis) or sildenafil (Revatio or Viagra)]? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Is the patient's age within FDA labeling for the requested indication for the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide rationale in support of using the requested agent for the patient's age for the requested indication: _____ _____	
<b>Please continue to the next page.</b>	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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7. Is the patient pregnant or planning to become pregnant while on therapy with the requested agent? .....  Yes  No
8. Does the patient have a mean pulmonary artery pressure greater than 20 mmHg? .....  Yes  No
9. Does the patient have a pulmonary capillary wedge pressure less than or equal to 15 mmHg? .....  Yes  No
10. Does the patient have a pulmonary vascular resistance greater than 2 Wood units? .....  Yes  No
11. Are there medical records showing the patient's diagnosis has been confirmed by right heart catheterization?  
**Please note, medical records are required.** .....  Yes  No
12. Does the requested quantity (dose) exceed the maximum FDA labeled dose for the requested indication? .....  Yes  No  
 If yes, is there information in support of therapy with a higher dose for the requested indication? .....  Yes  No  
 If yes, please provide supporting information \_\_\_\_\_  
 \_\_\_\_\_  
 If no, can the requested quantity (dose) be achieved with a lower quantity of a higher strength? .....  Yes  No  
 If no, please explain: \_\_\_\_\_  
 \_\_\_\_\_

**For requests for one of the following brand agents with a corresponding generic:**

Brand Agent	Corresponding Generic Agent
Revatio tablet	sildenafil tablet
Adcirca, Tadliq	tadalafil
Tracleer	bosentan
Letairis	ambrisentan
Revatio oral suspension, Liqrev	sildenafil oral suspension

**Please submit chart notes to support the answers to the following questions:**

13. Has the patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer? .....  Yes  No
14. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer? .....  Yes  No
15. If yes to either of the previous two questions, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration? .....  Yes  No
16. Has the patient tried and had an inadequate response to the corresponding generic? .....  Yes  No
17. Was the corresponding generic discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No
18. Does the patient have an intolerance or hypersensitivity to the corresponding generic that is not expected to occur with the requested agent? .....  Yes  No
19. Does the patient have an FDA labeled contraindication to the corresponding generic that is not expected to occur with the brand agent? .....  Yes  No
20. Is the corresponding generic expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? .....  Yes  No
21. Is the corresponding generic not in the best interest of the patient based on medical necessity? .....  Yes  No
22. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as the corresponding generic and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No
23. Is there support for the use of the requested brand agent over the corresponding generic? .....  Yes  No  
 If yes, please provide supporting information: \_\_\_\_\_  
 \_\_\_\_\_

**For Winrevair (sotatercept) requests:**

24. Has the patient been stable on background PAH therapy for at least 90 days? Please note: Background therapy refers to combination therapy consisting of drugs from two or more of the following drug classes: ERA, PDE5i, soluble guanylate cyclase stimulator, and/or prostacyclin analogue or receptor agonist.....  Yes  No
25. Is the patient pregnant or planning to become pregnant while on therapy with the requested agent? .....  Yes  No

**Please continue to the next page.**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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**For Reynaud's phenomenon requests:**

26. Is the patient concurrently taking an oral erectile dysfunction agent (e.g., Cialis, Levitra, Viagra) or a guanylate cyclase stimulator (e.g., Adempas)? .....  Yes  No
27. Has the patient tried a dihydropyridine calcium channel blocker (e.g., amlodipine, felodipine, nifedipine)? .....  Yes  No  
 If no, does the patient have an intolerance or hypersensitivity to a dihydropyridine calcium channel blocker?.....  Yes  No  
 If yes, please explain intolerance/hypersensitivity: \_\_\_\_\_
- \_\_\_\_\_
- If no, does the patient have an FDA labeled contraindication to ALL dihydropyridine calcium channel blockers?.....  Yes  No  
 If yes, please specify FDA labeled contraindication: \_\_\_\_\_
- \_\_\_\_\_

**For PAH, WHO Group 1 requests:**

28. Will the requested agent be used for monotherapy? .....  Yes  No  
 If no, please select how the requested agent will be used as add-on therapy and answer any corresponding questions:
- Dual therapy - Consist of 1 agent from 2 of the following therapeutic classes: an endothelin receptor antagonist (ERA), phosphodiesterase 5 inhibitor (PDE5i) and prostanoid
- Dual therapy - Consist of an ERA plus a soluble guanylate cyclase inhibitor (sGC) (Adempas)  
 Does the patient have unacceptable response to therapy with ERA plus a PDE5i? .....  Yes  No
- Triple therapy - Consist of an endothelin receptor antagonist (ERA) plus phosphodiesterase 5 inhibitor (PDE5i) plus a prostanoid  
 Has the patient been assessed as high risk using a PAH risk stratification tool or is WHO functional class IV? .....  Yes  No
- Triple therapy - Consist of an ERA plus PDE5i plus an activin-signaling inhibitor (Winrevar), or, an ERA plus a PDE5i plus a prostanoid  
 Has the patient had an inadequate response to established PAH pharmacotherapy with at least 2 or more of the following drug classes: ERA, PDE5i, and/or prostacyclin analogue or receptor agonist?.....  Yes  No
- Quadruple therapy  
 Are all four agents in the quadruple therapy from a different therapeutic class?.....  Yes  No  
 Has the patient been assessed as high risk using a PAH risk stratification tool or is WHO functional class IV? .....  Yes  No  
 Has the patient had an inadequate response to established PAH pharmacotherapy with at least 3 or more of the following drug classes: ERA, PDE5i, and/or prostacyclin analogue or receptor agonist?.....  Yes  No  
 Has a prostanoid been started as one of the agents in quadruple therapy? .....  Yes  No  
 Does the patient have an intolerance, FDA labeled contraindication, or hypersensitivity to ALL prostanoids? .....  Yes  No  
 If yes, please explain intolerance, contraindication, or hypersensitivity: \_\_\_\_\_
- \_\_\_\_\_
- Other

**For chronic thromboembolic pulmonary hypertension (CTEPH), WHO group 4:**

29. Has the patient's diagnosis been confirmed by a ventilation-perfusion scan and a confirmatory selective pulmonary angiography?.....  Yes  No  
 If yes, please explain: \_\_\_\_\_
30. Is the patient a candidate for surgery?.....  Yes  No  
 If yes, has the patient had a pulmonary endarterectomy AND has persistent or recurrent disease?.....  Yes  No

**For pulmonary hypertension associated with interstitial lung disease (PH-ILD, WHO group 3):**

31. Was the patient's PH\_ILD was assessed using key parts (e.g. risk factors for PAH and CTEPH, clinical features including disease trajectory, pulmonary function tests PFT) , brain natriuretic peptide [BNP]/N-terminal pro-BNP [NT-proBNP], cross-sectional imaging, and echocardiography)?.....  Yes  No
32. Does the patient have extensive parenchymal changes on computed tomography (CT)?.....  Yes  No
33. Is the patient currently treated with standard of care therapy for ILD (e.g., Ofev)? .....  Yes  No
34. Will the patient continue standard of care therapy for ILD (e.g., Ofev)? .....  Yes  No

**Please continue to the next page.**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
<p><b>For renewal requests:</b></p> <p>35. Has the patient had clinical benefit with the requested agent (e.g., stabilization, decreased disease progression)? <b>Please note, medical records are required.</b> ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>36. If the request is for Tyvaso for a diagnosis of pulmonary hypertension associated with interstitial lung disease (PH-ILD, WHO group 3), will the patient continue standard of care for ILD (e.g., Ofev)? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p><b>Please fax or mail this form to:</b>  Prime Therapeutics LLC  Clinical Review Department  2900 Ames Crossing Road Suite 200  Eagan, MN 55121</p> <p><b>TOLL FREE</b></p>		<p><b>CONFIDENTIALITY NOTICE:</b> This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.</p>	
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