Jefferson Health Plans

2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Adempas

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is Adempas being prescribed by or in consultation with a a cardiologist, or pulmonologist, or practitioner at a Pulmonary Hypertension Association-Accredited center?

☐ Yes ☐ No

Q2. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q3. Is the patient female and is of reproductive potential?

☐ Yes ☐ No

Q4. Did the patient have a negative pregnancy test and enroll in the manufacturer's risk evaluation and mitigation strategy (REMS) program prior to initiating Adempas? If yes, include confirmation of a negative pregnancy test prior to start of therapy and enrollment in the manufacturer's REMS program.

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q5. Does the member have the diagnosis of World Health Organization (WHO) Group 1 pulmonary arterial hypertension (PAH)?

☐ Yes ☐ No

Q6. Has the diagnosis of PAH been confirmed by a complete right catheterization (RHC) (please attach RHC report)? PAH is defined as: I. A mean pulmonary arterial pressure (mPAP) greater than 20 mmHg; II. A pulmonary capillary wedge pressure left ventricular end-diastolic pressure (PCWP/ LVEDP) less than or equal to 15 mmHg; III. A pulmonary vascular resistance (PVR) greater than 3 Wood units

☐ Yes ☐ No

Q7. Does the patient have WHO functional class II (Slight limitation of physical activity but comfortable at rest. Ordinary physical activity causes undue dyspnea of fatigue, chest pain, or near syncope) or III (Marked limitation of physical activity and comfortable at rest. Less than ordinary activity causes undue dyspnea or fatigue, chest pain, or near syncope)?

☐ Yes ☐ No

Q8. Does the member have the diagnosis of World Health Organization (WHO) Group 4 PAH?

☐ Yes ☐ No

Q9. Is there documentation confirming the diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH) and verifying patient has recurrent or persisting pulmonary hypertension following pulmonary thromboendarterectomy or inoperable CTEPH?

☐ Yes ☐ No

Q10. Will Adempas be used with nitrates, nitric oxide donors, or phosphodiesterase inhibitors?

☐ Yes ☐ No

Q11. Is there a treatment plan?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q12. Additional Information:

_____ _____

Prescriber Signature Date

2024 Prior Authorization Request