



2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Orenitram
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.

Form with fields for Patient Name, Prescriber Name, Member Number, Date of Birth, Line of Business, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, State Lic ID, and Specialty/facility name.

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.

Form with fields for Drug Name, Strength, and 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. Request Type:

Initial - Go to 2

Continuation - Go to 4

Q2. Is the requested medication being prescribed by or in consultation with a pulmonologist or cardiologist?

Yes

No

Q3. Does the patient have a diagnosis of Pulmonary Arterial Hypertension (PAH) and meets all of the following criteria?

A) Member has PAH defined as WHO Group 1 class of pulmonary hypertension

B) PAH was confirmed by either criterion (1) or criterion (2) below:

i. Pretreatment right heart catheterization with all of the following results: 1. mPAP > 20 mmHg; 2. PCWP = 15 mmHg; 3. PVR = 3 Wood units. ii. For infants less than one year of age, PAH was confirmed by Doppler echocardiogram if right heart catheterization cannot be performed? Please submit documentation.

Yes

No



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| | |
|----------------------|-------------------------|
| Patient Name: | Prescriber Name: |
|----------------------|-------------------------|

Q4. For continuation, is the patient experiencing benefit from therapy as evidenced by disease stability or disease improvement?

Yes

No

Q5. Additional Information:

Prescriber Signature

Date

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