Jefferson Health Plans

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 this request for reauthorization?

☐ Yes ☐ No

Q2. Is there confirmation of positive clinical response to therapy or stabilization?

☐ Yes ☐ No

Q3. Is Adempas being prescribed by or in consultation with a cardiologist, pulmonologist, or practitioner at a Pulmonary Hypertension Association-Accredited center?

☐ Yes ☐ No

Q4. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q5. Is the patient female and of reproductive potential?

☐ Yes ☐ No

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Q6. 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?

☐ Yes ☐ No

Q7. Does the member have the diagnosis of World Health Organization (WHO) Group 1 pulmonary arterial hypertension (PAH)?

☐ Yes ☐ No

Q8. 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 (PCWP) less than or equal to 15 mmHg ; III. A pulmonary vascular resistance (PVR) greater than 2 Wood units

☐ Yes ☐ No

Q9. 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

Q10. Does the member have the diagnosis of World Health Organization (WHO) Group 4 PAH?

☐ Yes ☐ No

Q11. 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

Q12. Will Adempas be used with nitrates, nitric oxide donors, or phosphodiesterase inhibitors OR is the patients pulmonary hypertension associated with idiopathic interstitial pneumonia (PH-IIP)?

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Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q13. Additional Information:	

Prescriber Signature _____ Date _____

v2025