Jefferson Health Plans

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.

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. Request Type:

☐ for an initial request - Go to 2 ☐ for a continuation request go to 7

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) defined as WHO Group 1 class of pulmonary hypertension?

☐ Yes ☐ No

Q4. Is the patient over the age of 1?

☐ Yes ☐ No

Q5. Pretreatment right heart catheterization with all of the following results:
a. Mean pulmonary arterial pressure (mPAP) > 20 mmHg
b. Pulmonary capillary wedge pressure (PCWP) ≤ 15 mmHg

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Patient Name:	**Prescriber Name:**

c. Pulmonary vascular resistance (PVR) ≥ 2 Wood units for adults OR for pediatric patients > 3 Wood units

☐ Yes ☐ No

Q6. For infants less than one year of age, was PAH was confirmed by Doppler echocardiogram if right heart catheterization cannot be performed?

☐ Yes ☐ No

Q7. For continuation, is the patient experiencing benefit from therapy as evidenced by disease stability or disease improvement?

☐ Yes ☐ No

Q8. Additional Information:

Prescriber Signature

Date

v2025