



PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Phosphodiesterase-5 Inhibitors

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: <input type="checkbox"/> 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 the request for reauthorization? If YES, go to 2. If NO, go to 3.

☐ Yes

☐ No

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

☐ Yes

☐ No

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

☐ Yes

☐ No

Q4. Will the patient take the drug in combination with either of the following: A) Organic nitrates, or B) guanylate cyclase (GC) stimulators (e.g., riociguat)?

☐ Yes

☐ No

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



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Patient Name:	Prescriber Name:
<div style="display: flex; justify-content: space-between;"><input type="checkbox"/> Yes<input type="checkbox"/> No</div> <p>Q6. Has the diagnosis of PAH been confirmed by a complete right heart catheterization (RHC) and are the RHC results provided? PAH defined as:</p> <ul style="list-style-type: none">o A mean pulmonary artery pressure (mPAP) greater than 20 mmHgo A pulmonary capillary wedge Pressure/ left ventricular end diastolic pressure (PCWPLVEDP) less than or equal to 15 mmHgo A pulmonary vascular resistance (PVR) greater than 2 Wood units. <div style="display: flex; justify-content: space-between;"><input type="checkbox"/> Yes<input type="checkbox"/> No</div>	
<p>Q7. Does the patient have a diagnosis of Raynaud's phenomenon?</p> <div style="display: flex; justify-content: space-between;"><input type="checkbox"/> Yes<input type="checkbox"/> No</div>	
<p>Q8. Has the patient had an inadequate response or intolerance to one calcium channel blocker?</p> <div style="display: flex; justify-content: space-between;"><input type="checkbox"/> Yes<input type="checkbox"/> No</div>	
<p>Q9. Additional Information:</p> 	

Prescriber Signature

Date

v2025