Jefferson Health Plans

# *PRIOR AUTHORIZATION REQUEST FORM*

Individual and Family Plans

## Uptravi

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

☐ Yes ☐ No

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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 (PCWP) less than or equal to 15 mmHg

III. A pulmonary vascular resistance (PVR) greater than 2 Wood units

☐ Yes ☐ No

Q7. Are chart notes provided documenting inadequate response, intolerance, or contraindication to ONE drug from TWO of the following classes:

I. Endothelin Receptor Antagonists (bosentan, ambrisentan, macitentan)

II. Phosphodiesterase-5 inhibitors (sildenafil, tadalafil)

III. Guanylate Cyclase stimulators (riociguat)

☐ Yes ☐ No

Q8. Will Uptravi be used along with a strong CYP2C8 inhibitor (eg gemfibrozil)?

☐ Yes ☐ No

Q9. Does the patient have hepatic impairment (Child Pugh Class B or greater) with lab monitoring and dose adjustments as needed?

☐ Yes ☐ No

Q10. Additional Information:

Prescriber Signature

Date

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*v2025*