

**2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM**



Phosphodiesterase 5 Inhibitors - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

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.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	<b>Specialty/facility name (if applicable):</b>	

**REQUEST FOR EXPEDITED REVIEW:** By checking this box and signing below, I certify that applying the 72 hour 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.**

<p><b>Q1. Is the prescriber a cardiologist, pulmonologist or rheumatologist?</b></p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p><b>Q2. Is the patient 18 years of age or older?</b></p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p><b>Q3. Will the patient take sildenafil in combination with either of the following: A) Organic nitrates, or B) Guanylate cyclase (GC) stimulators (e.g., riociguat)?</b></p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p><b>Q4. Does the patient have a diagnosis of World Health Organization (WHO) Group 1 pulmonary arterial hypertension (PAH)?</b></p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p><b>Q5. Has the diagnosis of PAH been confirmed by a complete right heart catheterization (RHC) and are the RHC results provided ? PAH defined as: A. A mean pulmonary artery pressure (mPAP) greater than 20 mmHg; B. A pulmonary capillary wedge Pressure/ left ventricular end diastolic pressure (PCWPLVEDP) less than or equal to 15 mmHg; C. A pulmonary vascular resistance (PVR) greater than 3 Wood units.</b></p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>

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<b>Patient Name:</b>	<b>Prescriber Name:</b>
Q6. Does the patient have a diagnosis of Raynaud's phenomenon? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. Has the patient had an inadequate response or intolerance to one calcium channel blocker? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Additional Information:	
Q9. Requested Duration: <input type="checkbox"/> 12 months <input type="checkbox"/> Other	

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

2024 Medicare Prior Authorization Request