



**MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM**

Winrevair - 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.

Member Name:	Prescriber Name:	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare Advantage	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 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.

Q1. 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

Q2. Is the request for reauthorization? If YES, go to 3. If NO, go to 5.

☐ Yes

☐ No

Q3. Is there confirmation of positive clinical response or stabilization?

☐ Yes

☐ No

Q4. Is there confirmation that the patient will remain on background PAH therapies while on Winrevair?

☐ Yes

☐ No

Q5. Does the patient have a 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 heart catheterization (RHC) and are the RHC results provided? PAH defined as:

☐ A mean pulmonary artery pressure (mPAP) greater than 20 mmHg

☐ A pulmonary capillary wedge Pressure/ left ventricular end diastolic pressure (PCWPLVEDP) less than or equal to 15 mmHg

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

Q7. Is there documentation showing that the patient is currently being treated with at least two PAH therapies from different pharmacologic categories unless there is a contraindication or intolerance (e.g., phosphodiesterase-5 inhibitor, endothelin receptor antagonist, prostacyclin agonist, guanylate cyclase stimulators)?

☐ Yes ☐ No

Q8. Is there confirmation that the patient will remain on background PAH therapies while on Winrevair?

☐ Yes ☐ No

Q9. Requested Duration:

☐ 12 Months ☐ Other:

Q10. Additional Information:

Prescriber Signature

Date

v2026