HEALTH PARTNERS PLANS

PRIOR AUTHORIZATION REQUEST FORM

Adcirca

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners 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:**
HPP Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Address:	NPI: Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*
Patient Primary Phone:	Address:
Line of Business: □ Medicaid	
□ CHIP	City, State ZIP:
	Specialty/facility name (if applicable):

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

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 prescribing physician a Cardiologist or Pulmonologist?

☐ Yes ☐ No

Q2. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q3. Does the patient have one of the following contraindications and concomitant medications? A. Concomitant organic nitrates B. Concomitant Guanylate Cyclase (GC) Stimulators

☐ Yes ☐ No

Q4. Does the patient have the diagnosis of World Health Organization (WHO) group 1 PAH?

☐ Yes ☐ No

Q5. Has the diagnosis of PAH been confirmed by a complete right heart catheterization (RHC) (please attach RHC report)? PAH defined as: A. A mean pulmonary artery pressure (mPAP) greater than 25 mm Hg B. A pulmonary capillary wedge Pressure/ left atrial pressure/left ventricular end-diastolic pressure (PCWP/LAP/LVEDP) less than or equal to 15 mm Hg C. A pulmonary vascular resistance (PVR) greater than 3 Wood units.

☐ Yes ☐ No

Q6. Does the patient have a postive response to an acute vasodilator testing (defined as a decrease in mPAP of at least 10 mm Hg to an absolute mPAP of less than 40 mm Hg without a decrease in cardiac output)?

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☐ Yes ☐ No

Q7. Has the patient tried and failed or had intolerance to sildenafil?

☐ Yes ☐ No

Q8. What is the patient's NYHA Functional Class? Please select from the following:

☐ I. No limitation/ordinary physical activity does not cause symptoms
☐ II. Slight limitation/comfortable at rest, ordinary physical activity causes symptoms
☐ III. Marked limitation/comfortable at rest, less than ordinary activity causes symptoms
☐ IV. Inability to carry on any physical activity/symptoms present at rest

Q9. Requested Duration:

☐ 12 months

Q10. Additional Information:

______________________________ ____________________

Prescriber Signature Date

Updated 2018

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