

Patient Name:

HPP Member Number:

HEALTH PARTNERS PLANS PRIOR AUTHORIZATION REQUEST FORM

Ambrisentan

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

Phone:

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.

Fax:

Prescriber Name:

Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	Prescriber PA PROMISe ID:	
Patient Primary Phone:	Address:	
Line of Business: Medicaid	City, State ZIP:	
□ CHIP	Specialty/facility name (if applicable):	
		,
Drug Name:	Expedited/Urgent	
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 Pulmono		
☐ Yes	☐ No	
Q2. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Q3. Is the patient female?		
☐ Yes	□ No	
Q4. If female, is the patient enrolled in the Letairis REMS	program?	
☐ Yes	□ No	
Q5. If female, is she pregnant?		
☐ Yes	☐ No	
Q6. If female, is she able to get pregnant?		
☐ Yes	□ No	
Q7. Will the patient (female) use reliable forms of contract	eption?	

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atient Name:	Prescriber Name:	
Yes	□ No	
Q8. Will the patient (female) have	nonthly pregnancy tests before therapy initiated and monthly during therapy?	
☐ Yes	□ No	
Q9. Does the patient have any ot	er contraindication to Letairis® such as Idiopathic Pulmonary Fibrosis?	
Yes	□ No	
Q10. Does the patient have the d	gnosis of World Health Organization (WHO) Group 1 PAH?	
Yes	□ No	
PAH defined as: A. A mean pulmwedge Pressure/ left atrial pressure	en confirmed by a complete right heart catheterization (please attach RHC report)? hary artery pressure (mPAP) greater than 25 mm Hg; B. A pulmonary capillary e/left ventricular end-diastolic pressure (PCWP/LAP/LVEDP) less than or equal to 15 esistance (PVR) greater than 3 Wood units? Must attach RHC report.	
Yes	□ No	
☐ II. Slight limitation/comforta☐ III. Marked limitation/ comforta	unctional Class? ical activity does not cause symptoms le at rest, ordinary physical activity causes symptoms table at rest, less than ordinary activity causes symptoms hysical activity/symptoms present at rest	
Q13. Will hemoglobin and hemate thereafter)?	rit levels be monitored periodically (baseline, at 1 month, and periodically	
Yes	□ No	
Q14. Requested Duration:		
6 Months		
Q15. Additional Information:		
Prescriber Sigr	ture Date	

Updated 2018