Health Partners Plans

HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

PAH Agents, Oral and Inhaled

Phone: 215-991-4300 Fax back to: 866-371-3239

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:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: □ Medicare	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 this a request for renewal of therapy (i.e., The requested drug has been previously approved by prior authorization)?
[If YES, skip to question 26.}

☐ Yes ☐ No

Q2. Is the request for Adcirca, Alyq, Revatio, sildenafil or tadalafil (phosphodiesterase type 5 inhibitors)?

☐ Yes ☐ No

Q3. Does the member have a diagnosis of pulmonary arterial hypertension (PAH)?

☐ Yes ☐ No

Q4. Is the prescribed agent being requested for the treatment of a diagnosis that is indicated in the United States Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication?

☐ Yes ☐ No

Q5. Does the member have a diagnosis of pulmonary arterial hypertension (PAH)?

☐ Yes ☐ No

Q6. Is the requested drug appropriate for the member's level of risk based on current risk calculator assessment (e.g., REVEAL 2.0) and current medical literature?

☐ Yes ☐ No

Q7. Is the prescribed dose consistent with Food and Drug Administration (FDA)-approved package labeling, nationally

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:**

recognized compendia or peer-reviewed medical literature?

☐ Yes ☐ No

Q8. Is the patient at least 18 years of age?

☐ Yes ☐ No

Q9. Is the requested drug prescribed by or in consultation with a pediatric pulmonologist, pediatric cardiologist or heart and lung transplant specialist?

☐ Yes ☐ No

Q10. Is the member able to access a Pulmonary Hypertension Association-accredited center?

☐ Yes ☐ No

Q11. Is the requested drug prescribed by or in consultation with a practitioner at a Pulmonary Hypertension Association-accredited center?

☐ Yes ☐ No

Q12. Is the requested drug prescribed by or in consultation with an appropriate specialist (e.g., pulmonologist, cardiologist or rheumatologist)?

☐ Yes ☐ No

Q13. Does the member have a history of contraindication to the prescribed medication?

☐ Yes ☐ No

Q14. Is the diagnosis chronic thromboembolic pulmonary hypertension (CTEPH)?
[If YES, skip to question 22.]

☐ Yes ☐ No

Q15. Is the diagnosis pulmonary arterial hypertension (PAH) World Health Organization (WHO) Group 1?

☐ Yes ☐ No

Q16. Does the member have a right heart catheterization indicating all of the following hemodynamic values:
A) Mean pulmonary arterial pressure greater than 20 millimeters of mercury,
B) Pulmonary capillary wedge pressure, left atrial pressure or left ventricular end-diastolic pressure less than or equal to 15 millimeters of mercury,
C) Pulmonary vascular resistance greater than 3 Wood units?
[Note: Please attach documentation.]

☐ Yes ☐ No

Q17. Does the member have idiopathic pulmonary arterial hypertension (PAH)?
[If YES, skip to question 23.

Health Partners Plans

HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

PAH Agents, Oral and Inhaled

Phone: 215-991-4300 **Fax back to: 866-371-3239**

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:**

☐ Yes	☐ No
Q18. Has the member undergone acute vasoreactivity testing? [Note: Please attach chart documentation.]	
☐ Yes	☐ No
Q19. Does the member have a contraindication to vasoreactivity testing or increased risk of adverse events during acute vasoreactivity testing (e.g., high risk stratification based on current risk calculator assessment (REVEAL 2.0), low systemic blood pressure, low cardiac index or pulmonary veno-occlusive disease)?	
☐ Yes	☐ No
Q20. Do the results of the testing demonstrate acute vasoreactivity?	
☐ Yes	☐ No
Q21. Has the member had therapeutic failure with or a contraindication or intolerance to calcium channel blockers (i.e., amlodipine, nifedipine or diltiazem)? [Note: Please attach documentation.]	
☐ Yes	☐ No
Q22. Does the member have both of the following hemodynamic values from right heart catheterization: A) Mean pulmonary arterial pressure greater than 25 millimeters of mercury, AND B) Pulmonary vascular resistance greater than 3 Wood units? [Note: Please attach documentation.]	
☐ Yes	☐ No
Q23. Is the request for a non-preferred pulmonary arterial hypertension (PAH) agent, oral and inhaled?	
☐ Yes	☐ No
Q24. Does the member have a history of therapeutic failure, contraindication or intolerance to the preferred pulmonary arterial hypertension (PAH) agents approved or medically accepted for the member's diagnosis or indication?	
☐ Yes	☐ No
Q25. Does the member have a current history (within the past 90 days) of being prescribed the same non-preferred pulmonary arterial hypertension (PAH) agent, oral and inhaled?	
☐ Yes	☐ No
Q26. Based on the prescriber's assessment, is there documentation of tolerability and a positive clinical response to the requested drug?	
☐ Yes	☐ No
Q27. Is the prescribed dose consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia or peer-reviewed medical literature?	

Health Partners Plans

HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

PAH Agents, Oral and Inhaled

Phone: 215-991-4300 **Fax back to: 866-371-3239**

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:**

☐ Yes	☐ No
Q28. Is the member at least 18 years old?	
☐ Yes	☐ No
Q29. Is the member able to access a Pulmonary Hypertension Association-accredited center?	
☐ Yes	☐ No
Q30. Is the requested drug prescribed by or in consultation with a practitioner at a Pulmonary Hypertension Association-accredited center?	
☐ Yes	☐ No
Q31. Is the requested drug prescribed by or in consultation with an appropriate specialist (e.g., pulmonologist, cardiologist or rheumatologist)?	
☐ Yes	☐ No
Q32. Is the requested drug prescribed by or in consultation with a pediatric pulmonologist, pediatric cardiologist or heart and lung transplant specialist?	
☐ Yes	☐ No
Q33. Does the member have a history of contraindication to the prescribed drug?	
☐ Yes	☐ No
Q34. Additional Information:	

Prescriber Signature

Date

2020 Medicare Prior Authorization Request