HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM
PULMONARY HYPERTENSION MEDICATIONS

Adempas®, Flolan®, Letairis®, Opsumit®, Orenitram®, Remodulin®, Tracleer®, Tyvaso®, Uptravi®, Veletri®, Ventavis®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to: 801-213-1547
- For **Retail Pharmacy** please fax requests to: 385-425-4052

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for Pharmacy Customer Service for assistance at 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ Adempas® (riociguat), ☐ ambrisentan, ☐ bosentan, ☐ epoprostenol, ☐ Opsumit® (macitentan), ☐ Orenitram® tablets, ☐ treprostinil intravenous, ☐ Uptravi® (selexipag)
Non-preferred: ☐ Ventavis® solution for inhalation
Non-Formulary: ☐ Remodulin® (treprostinil), ☐ Tracleer® (bosentan), ☐ Tyvaso® solution for inhalation

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis of Pulmonary Arterial Hypertension (PAH)?	☐	☐	**Please provide documentation**
2. Is the member classified as WHO (World health Organization) Group 1 pulmonary arterial hypertension? If not, please provide the WHO group classification.	☐	☐	**Please provide documentation**
3. Is the requesting provider a cardiologist or pulmonologist specializing in pulmonary hypertension?	☐	☐	
4. Does the member have regular follow up visits with the prescriber?	☐	☐	**Please provide documentation**
5. Has the member demonstrated at least 80% compliance with pulmonary hypertension medications?	☐	☐	**Please provide documentation**
6. If the member has a positive vasoreactivity test, have they had a trial and failure of oral calcium channel blocker therapy with dihydropyridine or diltiazem?	☐	☐	**Please provide documentation**

7. Has the member performed a baseline 6-minute walk test?	☐	☐	**Please provide documentation**
8. Is the member currently smoking or vaping?	☐	☐	
9. For member with a history of stimulant drug abuse, has a recent (within the past 30 days) clean urine drug screen (UDS) been provided?	☐	☐	**Please provide documentation**
ENDOTHELIN RECEPTOR ANTAGONISTS: AMBRISENTAN, BOSENTAN, OPSUMIT®			
1. Will the medication be used in combination with a phosphodiesterase inhibitor?	☐	☐	**Please provide documentation**
2. If the request is for Opsumit®, has ambrisentan been trialed and failed?	☐	☐	**Please provide documentation**
PROSTACYCLIN PATHWAY AGONISTS: ORENITRAM®, TREPROSTINIL IV, TREPROSTINIL SQ, REMODULIN®, TYVASO® UPTRAVI®, VENTAVIS®			
1. Does the following apply: Has the member tried and failed a PDE5 inhibitor in combination with ambrisentan or bosentan or does clinical documentation show a medical reason why the member cannot? • Is the member in WHO functional class III or IV?	☐	☐	**Please provide documentation**
2. For Tyvaso® and Ventavis® only, has the member had a trial and failure to treprostinil IV or SQ?	☐	☐	**Please provide documentation**
GUANYLATE CYCLASE STIMULATOR: ADEMPAS®			
1. Is the member in WHO functional class II, III or IV?	☐	☐	**Please provide documentation**
2. If the member has a clinical diagnosis of WHO group 1 PAH, have they tried and failed combination therapy with a PDE5 inhibitor with ambrisentan or bosentan?	☐	☐	**Please provide documentation**
3. Does the member have a clinical diagnosis of WHO Group 4 PAH after surgical treatment OR have confirmed inoperable chronic thromboembolic pulmonary hypertension?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation show disease improvement or stabilization (e.g. improvement in 6 minute walk test, functional class, pulmonary arterial pressure, cardiac index, etc.)?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician's Signature:

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Policy PHARM-HU-063
Origination Date: 01/01/2022
Reviewed/Revised Date: 11/08/2023
Next Review Date: 11/08/2024
Current Effective Date: 12/01/2023