

HEALTHY U CHIP

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)?	<input type="checkbox"/>	<input type="checkbox"/>	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.	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Is the requesting provider a cardiologist or pulmonologist specializing in pulmonary hypertension?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Does the member have regular follow up visits with the prescriber?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Has the member demonstrated at least 80% compliance with pulmonary hypertension medications?	<input type="checkbox"/>	<input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
7. Has the member performed a baseline 6-minute walk test?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

8. Is the member currently smoking or vaping?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
ENDOTHELIN RECEPTOR ANTAGONISTS: AMBRISENTAN, BOSENTAN, OPSUMIT®			
1. Will the medication be used in combination with a phosphodiesterase inhibitor?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. If the request is for Opsumit®, has ambrisentan been trialed and failed?	<input type="checkbox"/>	<input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. For Tyvaso® and Ventavis® only, has the member had a trial and failure to treprostinil IV or SQ?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
GUANYLATE CYCLASE STIMULATOR: ADEMPAS®			
1. Is the member in WHO functional class II, III or IV?	<input type="checkbox"/>	<input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation show disease improvement or stabilization (e.g. improvement in 6 minute walk test, functional class, pulmonary arterial pressure, cardiac index, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	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-CHIP-063
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024

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