UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Pulmonary Hypertension

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per Dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Select requested medication(s):

Preferred products are bold. *Non-Preferred Product Criteria also apply to (non-bolded) products.*

- ☐ Adempas (riociguat)
- ☐ Adcirca (**tadalafil**)
- ☐ Alyq (**tadalafil**)
- ☐ Flolan (**epoprostenol**)
- ☐ Letairis (**ambrisentan**)
- ☐ Opsumit (macitentan)
- ☐ Orenitram (treprostinil)
- ☐ Remodulin(treprostinil)
- ☐ Revatio (**sildenafil**)
- ☐ Tracleer (**bosentan**)
- ☐ Tyvaso (treprostinil)
- ☐ Uptravi (selexipag)
- ☐ Veletri (**epoprostenol**)
- ☐ Ventavis (iloprost)
- ☐ Other: _____

Criteria for Approval: (*All* of the following criteria must be met:)

- ☐ The medication is being prescribed by or in consultation with a pulmonologist or cardiologist.
- ☐ The patient has a diagnosis of pulmonary hypertension:
  - ☐ Group 1: Pulmonary Arterial Hypertension
    Patient has a history of WHO functional class (adult only): ☐ II ☐ III ☐ IV
  - ☐ Group 3: Interstitial Lung Disease (Tyvaso only)
  - ☐ Group 4: Chronic Thromboembolic Pulmonary Hypertension (CTEPH) after a surgical intervention or is inoperable (riociguat only)

☐ Indicate all the following medications the patient has trialed:

Nitric Oxide-cGMP Enhancers	Endothelin Receptor Antagonists	Prostacyclin Pathway Agonists
☐ Adcirca (tadalafil) ☐ Adempas (riociguat) ☐ Alyq (tadalafil) ☐ Revatio (sildenafil)	☐ Letairis (ambrisentan) ☐ Opsumit (macitentan) ☐ Tracleer (bosentan)	☐ Flolan (epoprostenol) ☐ Orenitram (treprostinil) ☐ Remodulin (treprostinil) ☐ Tyvaso (treprostinil) ☐ Uptravi (selexipag) ☐ Veletri (epoprostenol) ☐ Ventavis (iloprost)

Non-Preferred Product: (*Criteria above must also be met, and at least one of the following conditions must be met*)

- ☐ Trial and failure of the preferred product, per Utah Medicaid's PDL, or prescriber must demonstrate medical necessity for the non-preferred product. Details: _____
  Chart Note Page #: _____
- ☐ Continuation of Therapy: Member has been treated with the requested non-preferred drug at a consistent dosage for at least 60 days in most recent 90 days and the prescriber indicates the prescribed medication will best treat the member's condition. Details: _____
  Chart Note Page #: _____

Reauthorization Criteria:

- ☐ The patient has had clinically significant improvement as shown by the specific appropriate monitoring parameters and/or improvement in symptoms. Chart note page #: _____

Initial Authorization: 28 days for titration dosing (up to three (3) months for Uptravi), OR maintenance dosing = six (6) months

Reauthorization: Up to one (1) year

Note:

- ❖ Per federal regulation, Medicaid does not reimburse for drugs used for the treatment of sexual dysfunction or erectile dysfunction. Pharmacies should dispense only those products with pulmonary hypertension NDCs.

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date