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:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	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 applies 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** criteria must be met)*

- ❑ Medication prescribed by, or in consultation with a pulmonologist or cardiologist.
- ❑ Diagnosis of pulmonary hypertension:
  - ❑ Group 1: pulmonary arterial hypertension
  - ❑ Group 3: interstitial lung disease (Tyvaso only)
  - ❑ Group 4: chronic thromboembolic pulmonary hypertension (CTEPH) after surgical intervention or is inoperable (riociguat only)
- ❑ Adult patient has a history of WHO functional class: ☐ II ☐ III ☐ IV
- ❑ Indicate all of the following medications that the patient has trialed:

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

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

- ❑ Trial and failure of preferred product, per Utah Medicaid's PDL, or prescriber must demonstrate medical necessity for 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 #: _____

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.

Re-authorization Criteria:

Updated letter or updated chart notes supporting that the patient can benefit from the requested medication.

Authorization:

28 days for titration dosing (up to three (3) months for Uptravi), or maintenance dosing = six (6) months

Re-authorization:

Up to twelve (12) months

PROVIDER CERTIFICATION

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

_____ _____

Prescriber's Signature Date

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