pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

PULMONARY ARTERIAL HYPERTENSION AGENTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Pulmonary Arterial Hypertension** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION INFORMATION		**PRESCRIBER INFORMATION**	
☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested:

☐Adcirca tablet*
☐Adempas tablet
☐Opsumit tablet*
☐Orenitram ER tablet
☐Revatio suspension*
☐Revatio tablet*
☐sildenafil tablet* (*preferred with clinical prior auth required)*
☐tadalafil tablet*
☐Tracleer tablet for oral suspension
☐Tyvaso inhalation system refill kit
☐Tyvaso inhalation system starter kit
☐Tyvaso inhalation solution ampule
☐Uptravi tablet
☐Uptravi titration pack
☐_____

Strength:	Dose/directions:	Quantity:	Refills:

Diagnosis (*submit documentation*):	Dx code (*required*):
* These agents are part of the Specialty Pharmacy Drug Program. Which specialty pharmacy will be used?	☐Diplomat Specialty Pharmacy ☐Walgreen's Specialty Pharmacy

PEDIATRIC requests (beneficiaries < 18 years of age)

1. What is the beneficiary's weight?	_____ lb / kg
2. If the requested medication is prescribed *in consultation with* a specialist, *submit documentation of consultation and consultant's specialty*.	

ADULT requests (beneficiaries ≥ 18 years of age) – answer all questions applicable to drug requested

1. ***PDE5 inhibitors (Adcirca*/tadalafil*, Revatio*/sildenafil*):*** Does the beneficiary have diagnosis of pulmonary arterial hypertension (PAH)?	☐Yes – *Submit all supporting documentation.* ☐No
2. ***Non-preferred PDE5 inhibitors (Adcirca tablet*, Revatio suspension*/tablet*, and tadalafil tablet*):*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred PDE5 inhibitor, **sildenafil tablet***?	☐Yes ☐No *Submit documentation of medication regimens tried and treatment responses, contraindications, and/or intolerances.*
3. ***Adempas, Opsumit*, Orenitram ER, Tracleer tablet for oral suspension, Tyvaso, Uptravi*:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred PAH agents? *Check all that apply.* ☐Letairis tablet* ☐Tracleer tablet* ☐sildenafil tablet* ☐Ventavis inhalation solution	☐Yes ☐No *Submit documentation of medication regimens tried and treatment responses, contraindications, and/or intolerances.*
4. ***Adempas:*** Is the beneficiary being treated for persistent/recurrent chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4) after surgical treatment or inoperable CTEPH?	☐Yes ☐No *Submit documentation.*
5. ***ALL non-preferred agents:*** Has the beneficiary been taking the requested non-preferred medication within the past 90 days?	☐Yes ☐No *Submit documentation of drug regimen and clinical response.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: