

PULMONARY ARTERIAL HYPERTENSION (PAH) AGENTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Pulmonary Arterial Hypertension Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:			NPI:	State license #:
LTC facility contact/phone:			Street address:	
Beneficiary name:			Suite #:	City/state/zip:
Beneficiary ID#:		DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug Name:	Strength:	Formulation:	
Dose/directions:		Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):		DX code (<i>required</i>):	
Has the beneficiary been taking the requested medication within the past 90 days?		<input type="checkbox"/> Yes	<i>Submit documentation of drug regimen and clinical response.</i>
		<input type="checkbox"/> No	

INITIAL requests

For a non-preferred PAH Agent: Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred agents in this class that are approved or medically accepted for treatment of the beneficiary's condition? Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred agents in this class.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation.</i>
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Complete the sections below that are applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

For treatment of PAH:

- The requested medication is appropriate for the beneficiary's level of risk based on a current risk calculator assessment (e.g., REVEAL 2.0) and current medical literature
- Has a mean pulmonary arterial pressure greater than 20 mmHg
- Has a pulmonary capillary wedge pressure, left atrial pressure, or left ventricular end-diastolic pressure less than or equal to 15 mmHg
- Has a pulmonary vascular resistance greater than 3 Wood units

Also, for idiopathic PAH:

- Has chart documentation of acute vasoreactivity testing or a medical reason for not having vasoreactivity testing
- Demonstrates acute vasoreactivity and has a history of trial and failure of or contraindication or intolerance to calcium channel blockers

For treatment of CTEPH:

- Has a mean pulmonary arterial pressure greater than 25 mmHg
- Has a pulmonary vascular resistance greater than 3 Wood units

RENEWAL requests

Has the beneficiary experienced a positive clinical response to the requested medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation of clinical response.</i>
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PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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