

UPMC HEALTH PLAN

Pulmonary Arterial Hypertension Agents:

Revatio, Letairis, Tracleer, Flolan, Remodulin, Ventavis, Veletri, Adcirca, Tyvaso

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES

PHONE 800-979-UPMC (8762)

FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.

Office Contact:		Provider Specialty:	
Provider First Name:		Provider Last Name:	
Provider Phone:		Provider Fax:	Provider NPI #:
Patient Name:	Patient UPMC Health Plan ID Number:	Patient DOB:	Patient Age:
Drug Requested: <input type="checkbox"/> Brand <input type="checkbox"/> Generic	Strength:	Frequency:	Qty Dispensed:
<i>Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.</i>			
<input type="checkbox"/> New Medication <input type="checkbox"/> Ongoing Medication	If Ongoing Provide Date Started:	If medication is ongoing, did the member show improvement while on therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosis:		Date of diagnosis:	
Please indicate place of administration:	<input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital/Clinic	Will the drug be: (select one) <input type="checkbox"/> Billed directly by the provider via JCODE JCODE: _____ <input type="checkbox"/> Billed by a pharmacy and delivered to the provider <input type="checkbox"/> Billed by a pharmacy and delivered to the patient	
Please provide hospital/facility name and address:			
Medical History			
Please complete the following questions for all diagnoses and drug requests.			
Was the diagnosis confirmed by right heart catheterization?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Please indicate World Health Organization (WHO) functional class symptoms.		<input type="checkbox"/> Class I	<input type="checkbox"/> Class II
		<input type="checkbox"/> Class III	<input type="checkbox"/> Class IV
Please indicate the requested drug on the left and complete the corresponding questions.			
<input type="checkbox"/> Revatio <input type="checkbox"/> Adcirca	Is the member currently taking a nitrate product?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Letairis <input type="checkbox"/> Tracleer	Has the member had baseline liver function tests prior to initiation of therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If member is a woman of childbearing potential, has she had a negative pregnancy test prior to initiation of therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> Not applicable	<input type="checkbox"/> No
Please provide any additional information which should be considered in the space below:			