

# UPMC HEALTH PLAN

## Pulmonary Hypertension Agents:

**Adcirca, Revatio, Adempas, LETAIRIS\*\*, Tracleer, Opsumit, Flolan, Remodulin,  
Tyvaso, Veletri, Ventavis**

### 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.*

<b>Office Contact:</b>		<b>Provider Specialty:</b> <input type="checkbox"/> Cardiologist <input type="checkbox"/> Pulmonologist <input type="checkbox"/> Other, please list:	
<b>Provider First Name:</b>		<b>Provider Last Name:</b>	
<b>Provider Phone:</b>		<b>Provider Fax:</b>	<b>Provider NPI #:</b>
<b>Patient Name:</b>	<b>Patient UPMC Health Plan ID Number:</b>	<b>Patient DOB:</b>	<b>Patient Age:</b>
<b>Drug Requested:</b> <input type="checkbox"/> Brand <input type="checkbox"/> Generic	<b>Strength:</b>	<b>Frequency:</b>	<b>Qty Dispensed:</b>
<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	<b>If Ongoing Provide Date Started:</b>	<b>If medication is ongoing, did the member show improvement while on therapy?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Diagnosis:</b>		<b>Date of diagnosis:</b>	
<b>Please indicate place of administration:</b>	<input type="checkbox"/> Physician Office <input type="checkbox"/> Hospital/Clinic <input type="checkbox"/> Patient Home	<b>Will the drug be: (select one)</b> <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	
<b>Please provide hospital/facility name and address:</b>			

**Please complete the following questions for *all* diagnoses and drug requests.**

<b>Is the provider a member of the Pulmonary Hypertension Association?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Please attach chart documentation of right heart catheterization confirming diagnosis of pulmonary arterial hypertension. The following hemodynamic values must be included:</b> <ul style="list-style-type: none"> <li>➤ Mean pulmonary arterial pressure (mPAP)</li> <li>➤ Pulmonary capillary wedge pressure (PCWP) OR left atrial pressure OR left ventricular end-diastolic pressure (LVEDP)</li> <li>➤ Pulmonary vascular resistance (PVR) OR Cardiac Output</li> </ul>	<input type="checkbox"/> Documentation enclosed <input type="checkbox"/> Documentation not available
<b>Please specify WHO Etiologic Classification of Pulmonary Hypertension:</b>	<input type="checkbox"/> Group 1 <input type="checkbox"/> Group 4 <input type="checkbox"/> Group 2 <input type="checkbox"/> Group 5 <input type="checkbox"/> Group 3
<b>Please indicate WHO functional class symptoms:</b>	<input type="checkbox"/> Class I <input type="checkbox"/> Class III <input type="checkbox"/> Class II <input type="checkbox"/> Class IV
<b>If the member is a woman of childbearing potential, has she had a baseline negative pregnancy test prior to initiation of therapy?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
<b>Is the member currently taking a nitrate product?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please be sure to complete and include the 2nd page of this form.

**\*\*LETAIRIS IS THE PREFERRED ENDOTHELIN RECEPTOR ANTAGONIST FOR UPMC HEALTH PLAN.**

## Pulmonary Arterial Hypertension Agents

### Page 2

Patient Name	Patient UPMC Health Plan ID Number	Patient DOB
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Please be sure to complete and include this page with the 1st page of this form.

Will the requested medication be used as monotherapy or combination therapy?	<input type="checkbox"/> Monotherapy <input type="checkbox"/> Combination
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If used as combination therapy, please list other drug(s):

Medication Name	Strength	Dose Frequency

Please indicate the requested drug on the left and complete the corresponding questions.

<input type="checkbox"/> Adcirca	Has the member previously tried sildenafil (Revatio)? > Please provide dates of therapy: _____ > Please provide reason for discontinuation: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<input type="checkbox"/> Adempas	For Pulmonary Arterial Hypertension, PAH (WHO Group 1)	
	Has the member previously tried sildenafil (Revatio)? > Please provide dates of therapy: _____ > Please provide reason for discontinuation: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	For Chronic Thromboembolic Pulmonary Hypertension, CTEPH (WHO Group 4):	
	Has the member previously failed surgical treatment (such as a pulmonary endarterectomy)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does the member have inoperable CTEPH?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please attach chart documentation of ventilation-perfusion scan or pulmonary angiography confirming the diagnosis of CTEPH.	<input type="checkbox"/> Documentation enclosed <input type="checkbox"/> Documentation not available	

<input type="checkbox"/> Tracleer	Has the member previously tried Letairis? > Please provide dates of therapy: _____ > Please provide reason for discontinuation: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Is the member currently taking glyburide or cyclosporine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Has the member had baseline liver function tests prior to initiation of therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<input type="checkbox"/> Opsumit	Has the member previously tried Letairis? > Please provide dates of therapy: _____ > Please provide reason for discontinuation: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Has the member had baseline hemoglobin level prior to initiation of therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Has the member had baseline liver function tests prior to initiation of therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please provide any additional information which should be considered in the space below: