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.

Office Contact:	**Provider Specialty:** ❑ Cardiologist ❑ Pulmonologist ❑ Other, please list:		
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: ❑ Brand ❑ Generic	**Strength:**	**Frequency:**	**Qty Dispensed:**

Generic equivalent drugs will be substituted for brand-name drugs unless you specifically indicate otherwise.

❑ New Medication ❑ Ongoing Medication	**If Ongoing Provide Date Started:**	**If medication is ongoing, did the member show improvement while on therapy?**	❑ Yes ❑ No
Diagnosis:		**Date of diagnosis:**	

Please indicate place of administration:	❑ Physician Office ❑ Hospital/Clinic ❑ Patient Home	**Will the drug be: (select one)** ❑ Billed directly by the provider via JCODE JCODE: _____ ❑ Billed by a pharmacy and delivered to the provider ❑ Billed by a pharmacy and delivered to the patient
Please provide hospital/facility name and address:		

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

Is the provider a member of the Pulmonary Hypertension Association?	❑ Yes ❑ No
Please attach chart documentation of right heart catheterization confirming diagnosis of pulmonary arterial hypertension. The following hemodynamic values must be included: ➢ **Mean pulmonary arterial pressure (mPAP)** ➢ **Pulmonary capillary wedge pressure (PCWP) OR left atrial pressure OR left ventricular end-diastolic pressure (LVEDP)** ➢ **Pulmonary vascular resistance (PVR) OR Cardiac Output**	❑ Documentation enclosed ❑ Documentation not available
Please specify WHO Etiologic Classification of Pulmonary Hypertension:	❑ Group 1 ❑ Group 4 ❑ Group 2 ❑ Group 5 ❑ Group 3
Please indicate WHO functional class symptoms:	❑ Class I ❑ Class III ❑ Class II ❑ Class IV
If the member is a woman of childbearing potential, has she had a baseline negative pregnancy test prior to initiation of therapy?	❑Yes ❑No ❑Not applicable
Is the member currently taking a nitrate product?	❑Yes ❑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

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?	❑ **Monotherapy** ❑ **Combination**

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.

❑ **Adcirca**	**Has the member previously tried sildenafil (Revatio)?** ➢ **Please provide dates of therapy:_____** ➢ **Please provide reason for discontinuation:_____**	❑**Yes**	❑**No**
❑ **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:_____**	❑**Yes**	❑**No**
	For Chronic Thromboembolic Pulmonary Hypertension, CTEPH (WHO Group 4):		
	Has the member previously failed surgical treatment (such as a pulmonary endarterectomy)?	❑**Yes**	❑**No**
	Does the member have inoperable CTEPH?	❑**Yes**	❑**No**
	Please attach chart documentation of ventilation-perfusion scan or pulmonary angiography confirming the diagnosis of CTEPH.	❑ **Documentation enclosed** ❑ **Documentation not available**	
❑ **Tracleer**	**Has the member previously tried Letairis?** ➢ **Please provide dates of therapy:_____** ➢ **Please provide reason for discontinuation:_____**	❑**Yes**	❑**No**
	Is the member currently taking glyburide or cyclosporine?	❑**Yes**	❑**No**
	Has the member had baseline liver function tests prior to initiation of therapy?	❑**Yes**	❑**No**
❑ **Opsumit**	**Has the member previously tried Letairis?** ➢ **Please provide dates of therapy:_____** ➢ **Please provide reason for discontinuation:_____**	❑**Yes**	❑**No**
	Has the member had baseline hemoglobin level prior to initiation of therapy?	❑**Yes**	❑**No**
	Has the member had baseline liver function tests prior to initiation of therapy?	❑**Yes**	❑**No**

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