



Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/completecure-forproviders/pharmacy

Pulmonary Arterial Hypertension Agents Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information					
Member Name (first & last):		Date of Birth:		Gender:	
Member ID:		City:		State:	
				Height:	
				Weight:	
				<input type="checkbox"/> Male <input type="checkbox"/> Female	
Prescribing Provider Information					
Provider Name (first & last):		Specialty:		NPI#	
Office Address:		City:		State:	
				DEA#	
				Zip Code:	
Office Contact:		Office Phone		Office Fax:	
Dispensing Pharmacy Information					
Pharmacy Name:		Pharmacy Phone:		Pharmacy Fax:	
Requested Medication Information					
Preferred Agents:		<input type="checkbox"/> Tracleer Tablets <input type="checkbox"/> Letairis <input type="checkbox"/> Adcirca <input type="checkbox"/> Sildenafil <input type="checkbox"/> Revatio suspension			
Non-Preferred Agents:		<input type="checkbox"/> Revatio tab <input type="checkbox"/> Upravi <input type="checkbox"/> Orenitram ER <input type="checkbox"/> Opsumit <input type="checkbox"/> Adempas			
		<input type="checkbox"/> epoprostenol <input type="checkbox"/> Veletri <input type="checkbox"/> Remodulin <input type="checkbox"/> treprostinil <input type="checkbox"/> Tyvaso			
		<input type="checkbox"/> Ventavis <input type="checkbox"/> Other, please specify: _____			
Are there any contraindications to formulary medications?				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> New request <input type="checkbox"/> Continuation of therapy request	
If yes, please specify: _____					
For continuation of therapy requests ONLY:		<input type="checkbox"/> Response to therapy <input type="checkbox"/> Maintained OR achieved low risk profile (for example, improvement in 6 min walk distance, functional class, or reducing time to clinical worsening)			
Directions for Use:		Strength:		Dosage Form:	
		Quantity:		Day Supply:	
				Duration of Therapy/Use:	
What medication(s) has member tried and failed for this diagnosis? Please specify: _____					
Medication request is NOT for an FDA approved, or compendia-supported diagnosis (circle one): Yes No			Diagnosis:		ICD-10 Code:
Turn-Around Time for Review					
<input type="checkbox"/> Standard – (24 hours)			<input type="checkbox"/> Urgent – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision.		
			Signature: _____		
Clinical Information - General Authorization Criteria					
Was there evidence of right heart catheterization with mPAP ≥25mmHg?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Is diagnosis of Pulmonary Arterial Hypertension WHO Group I with Functional Class II to IV symptoms?	
Did member have inadequate response OR intolerance to a CCB?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Was there a contraindication to use of CCBs?	
Did member have a negative vasoreactivity test?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Was there a contraindication to vasoreactivity test? (for example, low BP, low cardiac index, OR presence of severe Functional Class IV symptoms?)	
Did member have a positive vasoreactivity test with inadequate response OR intolerance to ONE CCB? (for example,		<input type="checkbox"/> Yes <input type="checkbox"/> No		Will there be concurrent use of nitrate OR nitric oxide donors such as isosorbide mononitrate, isosorbide dinitrate OR	

amlodipine, nifedipine ER OR diltiazem)			nitroglycerin: Phosphodiesterase Type 5 Inhibitors AND Adempas?		
Is member pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does member have hepatic impairment (Child Pugh class C)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does member have Pulmonary veno-occlusive disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does member have HF with severe left ventricular dysfunction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Additional Drug Specific Criteria					
<input type="checkbox"/> Brand Revatio Oral Suspension					
Does member an inability to swallow solid dosage form?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Adempas					
Is diagnosis of WHO Pulmonary Arterial Hypertension Group I with NYHA Functional Class II to IV symptoms?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Member had trial AND failure with ONE preferred oral agent from each class (check that apply):		(PDE-5) Inhibitor		Endothelin Receptor Antagonist	
		<input type="checkbox"/> Sildenafil		<input type="checkbox"/> Tracleer tablets	
		<input type="checkbox"/> Tadalafil		<input type="checkbox"/> Letairis	
Is diagnosis for Chronic Thromboembolic Pulmonary Hypertension, WHO Group IV?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there recurrent OR persistent Chronic Thromboembolic Pulmonary Hypertension after surgical treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does member have inoperable Chronic Thromboembolic Pulmonary Hypertension?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Upravi - Orenitram					
Does member have severe hepatic impairment (Child-Pugh class C)?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Trial AND failure with ONE preferred oral agent from each class (check that apply):		(PDE-5) inhibitor		Endothelin Receptor Antagonist	
		<input type="checkbox"/> Sildenafil		<input type="checkbox"/> Tracleer tablets	
		<input type="checkbox"/> Tadalafil		<input type="checkbox"/> Letairis	
<input type="checkbox"/> Tyvaso - Ventavis - Remodulin - treprostinil					
<u>Tyvaso and Ventavis ONLY:</u> Does member have NYHA Functional Class III-IV symptoms?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<u>Remodulin ONLY:</u> Does member have NYHA Functional Class II-IV symptoms?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Trial AND failure with ONE preferred oral agent from each class (check that apply):		(PDE-5) inhibitor		Endothelin Receptor Antagonist	
		<input type="checkbox"/> Sildenafil		<input type="checkbox"/> Tracleer tablets	
		<input type="checkbox"/> Tadalafil		<input type="checkbox"/> Letairis	
Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records					

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required. Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request.