mercy care

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/chp-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: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information					
Preferred Agents:	☐ Tracleer Tablets	☐ Letairis	☐ Adcirca	☐ Sildenafil	☐ Revatio suspension
Non-Preferred Agents:	☐ Revatio tab	☐ Uptravi	☐ Orenitram ER	☐ Opsumit	☐ Adempas
	☐ epoprostenol	☐ Veletri	☐ Remodulin	☐ treprostinil	☐ Tyvaso
	☐ Ventavis	☐ Other, please specify:			

Are there any contraindications to formulary medications? If yes, please specify:	☐ Yes	☐ No	☐ New request	☐ Continuation of therapy request
For continuation of therapy requests ONLY:	☐ Response to therapy	☐ 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	
☐ Standard – (24 hours)	☐ **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?	☐ Yes	☐ No	Is diagnosis of Pulmonary Arterial Hypertension WHO Group I with Functional Class II to IV symptoms?	☐ Yes	☐ No
Did member have inadequate response OR intolerance to a CCB?	☐ Yes	☐ No	Was there a contraindication to use of CCBs?	☐ Yes	☐ No
Did member have a negative vasoreactivity test?	☐ Yes	☐ No	Was there a contraindication to vasoreactivity test? (for example, low BP, low cardiac index, OR presence of severe Functional Class IV symptoms?	☐ Yes	☐ No
Did member have a positive vasoreactivity test with inadequate response OR intolerance to ONE CCB? (for example,	☐ Yes	☐ No	Will there be concurrent use of nitrate OR nitric oxide donors such as isosorbide mononitrate, isosorbide dinitrate OR	☐ Yes	☐ No

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amlodipine, nifedipine ER OR diltiazem)			nitroglycerin: Phosphodiesterase Type 5 Inhibitors AND Adempas?		
Is member pregnant?	☐ Yes	☐ No	Does member have hepatic impairment (Child Pugh class C)?	☐ Yes	☐ No
Does member have Pulmonary veno-occlusive disease?	☐ Yes	☐ No	Does member have HF with severe left ventricular dysfunction?	☐ Yes	☐ No

Additional Drug Specific Criteria

☐ **Brand Revatio Oral Suspension**

Does member an inability to swallow solid dosage form?	☐ Yes	☐ No

☐ **Adempas**

Is diagnosis of WHO Pulmonary Arterial Hypertension Group I with NYHA Functional Class II to IV symptoms?	☐ Yes	☐ No

Member had trial AND failure with ONE preferred oral agent from each class (check that apply):	**(PDE-5) Inhibitor**	**Endothelin Receptor Antagonist**
	☐ Sildenafil	☐ Tracleer tablets
	☐ Tadalafil	☐ Letairis

Is diagnosis for Chronic Thromboembolic Pulmonary Hypertension, WHO Group IV?	☐ Yes	☐ No	Was there recurrent OR persistent Chronic Thromboembolic Pulmonary Hypertension after surgical treatment?	☐ Yes	☐ No
Does member have inoperable Chronic Thromboembolic Pulmonary Hypertension?				☐ Yes	☐ No

☐ **Uptravi - Orenitram**

Does member have severe hepatic impairment (Child-Pugh class C)?	☐ Yes	☐ No

Trial AND failure with ONE preferred oral agent from each class (check that apply):	**(PDE-5) inhibitor**	**Endothelin Receptor Antagonist**
	☐ Sildenafil	☐ Tracleer tablets
	☐ Tadalafil	☐ Letairis

☐ **Tyvaso - Ventavis - Remodulin - treprostinil**

Tyvaso and Ventavis ONLY: Does member have NYHA Functional Class III-IV symptoms?	☐ Yes	☐ No	Remodulin ONLY: Does member have NYHA Functional Class II-IV symptoms?	☐ Yes	☐ No

Trial AND failure with ONE preferred oral agent from each class (check that apply):	**(PDE-5) inhibitor**	**Endothelin Receptor Antagonist**
	☐ Sildenafil	☐ Tracleer tablets
	☐ Tadalafil	☐ 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 833-711-0776 to check the status of a request.

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