# PRIOR AUTHORIZATION REQUEST FORM

Well Sense 9.128 Pulmonary Hypertension - 1
Epoprostenol injection, Letairis, Opsumit, Orenitram, Remodulin, Sildenafil (Revatio), Revatio Oral Susp, Tracleer, Tyvaso, Uptravi, Veletri, Ventavis
Version 13.0
Effective Date 5/2/17

**Phone: 877-957-1300 Fax back to: 866-305-5739**

ENVISION RX OPTIONS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

| **Patient Name:** | **Prescriber Name:** | |
|---|---|---|
| Member/Subscriber Number: | Fax: | Phone: |
| Date of Birth: | Office Contact: | |
| Group Number: | NPI: | State Lic ID: |
| Address: | Address: | |
| City, State ZIP: | City, State ZIP: | |
| Primary Phone: | Specialty/facility name (if applicable): | |

☐ Expedited/Urgent

Drug Name and Strength:
Directions / SIG:

**Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.**

Q1. Which medication is the request for?

- ☐ Epoprostenol injection
- ☐ Letairis
- ☐ Opsumit
- ☐ Orenitram
- ☐ Remodulin
- ☐ Revatio Oral Suspension
- ☐ Sildenafil (Revatio)
- ☐ Tracleer
- ☐ Tyvaso
- ☐ Veletri
- ☐ Ventavis
- ☐ Uptravi

Q2. Is the request for initial or continuing therapy?

☐ Initial ☐ Continuing

WELL SENSE HEALTH PLAN

ENVISIONRx

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| **Patient Name:** | **Prescriber Name:** |
|---|---|

Q3. If CONTINUING therapy please indicate the start date (MM/YY):

Q4. Does the patient have a diagnosis of Group 1-PAH?
☐ Yes ☐ No

Q5. Is the patient's pulmonary artery pressure greater than 25mmHg at rest or greater than 30mmHg with exertion?
☐ Yes ☐ No

Q6. Has the patient's symptoms of PAH progressed despite medical or surgical treatment of the underlying disorder?
☐ Yes ☐ No

Q7. Please provide the NYHA functional classification.

Q8. Has the patient had a negative acute vasoreactivity testing?
☐ Yes ☐ No

Q9. Has the patient tried and failed calcium channel blockers or has a contraindication to them?
☐ Yes ☐ No

Q10. If coverage of medication is approved, how will this medication be supplied? (Please check one)
☐ Order through Plan Preferred Specialty Pharmacy
☐ Provider/Hospital Buy & Bill

Q11. Please provide the following information if the prescribers office will be supplying the medication to the patient (Buy and Bill): J-Codes:_____ Procedure codes(s) for administration:_____
Number of units and visits:_____ Date of planned adminstration:_____

_____ _____
Prescriber Signature Date