Pulmonary Arterial Hypertension (Infusible, Inhalation, or Injectable Medication) Precertification Request

(All fields must be completed and legible for Precertification Review)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy, Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:
Patient Current Weight: _____ lbs or _____ kgs Patient Height: _____ inches or _____ cms		Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____	Does patient have other coverage? ☐ Yes ☐ No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured:	Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one)*: ☐ **Cardiologist** ☐ **Pulmonologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: ☐ epoprostenol ☐ Flolan ☐ Remodulin ☐ Tyvaso ☐ Veletri ☐ Ventavis
Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: ☐ _____ ☐ Other: _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For All Requests

1. What is the World Health Organization classification of the symptoms of the patient's pulmonary hypertension? *(check one)* ☐ I ☐ II ☐ III ☐ IV
2. What was the mean pulmonary artery pressure documented by right-heart catheterization (RHC) or echocardiography:
   a. At rest: _____ mmHg b. With exertion: _____ mmHg
3. ☐ Yes ☐ No Does the patient have a diagnosis of primary pulmonary hypertension?
   ☐ Yes ☐ No Is there clinical evidence of pulmonary hypertension secondary to any of the following conditions? ***If yes***, please identify:
   ☐ Chronic thromboembolic pulmonary hypertension (CTEPH) not adequately responsive to anticoagulants or surgical thromboendarterectomy
   ☐ Anorectic agents (diet drugs) ☐ Congenital diaphragmatic hernia ☐ Congenital heart disease with shunting
   ☐ Connective tissue diseases ☐ Familial pulmonary hypertension ☐ HIV infection
   ☐ Portopulmonary hypertension ☐ Sarcoidosis ☐ Other:_____
4. ☐ Yes ☐ No ☐ NA***** Has the patient had an acute vasoreactivity test?
   ☐ Yes ☐ No Did the patient have a **positive** acute vasoreactivity test result (defined as a decrease in mPAP (mean pulmonary artery pressure) by at least 10 mm Hg to an absolute level of less than 40 mg Hg without a decrease in cardiac output)?
   ☐ Yes ☐ No Does the patient have a documented trial and failure of a calcium channel blocker (dihydropyridine or diltiazem)?
   ☐ Yes ☐ No Does the patient have a contraindication to a calcium channel blocker (e.g., right heart failure, hemodynamic instability)?

   ***** *Patient has pulmonary hypertension secondary to sarcoidosis, congenital diaphragmatic hernia chronic thromboembolic pulmonary hypertension, right heart failure, low systemic blood pressure, low cardiac index, or the presence of severe (functional class IV) symptoms.*
5. ☐ Yes ☐ No If female, is the patient pregnant?

Requests for continuous infusion of epoprostenol, Flolan, Veletri, or Remodulin:
☐ Yes ☐ No Does the patient have severe pulmonary vascular disease refractory to medical therapy?
☐ Yes ☐ No Will the continuous infusion be used as a bridge to either lung or combined heart-lung transplantation?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required)*: _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.