Pulmonary Arterial Hypertension (Oral Medications) Precertification Request

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

Aetna Precertification Notification
Phone: 1-855-240-0535
FAX: 1-877-269-9916

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:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
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: ☐ Adcirca ☐ Adempas ☐ Letairis ☐ Tracleer ☐ Opsumit ☐ Orenitram ☐ Revatio ☐ sildenafil ☐ Uptravi
Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

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) 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?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

Requests for Adcirca, tadalafil, Revatio, or sildenafil:

☐ Yes ☐ No Is the patient concurrently on organic nitrates (e.g., *isosorbide mononitrate, isosorbide dinitrate, nitroglycerin*)?

☐ Yes ☐ No Is the patient currently utilizing Adcirca?

Requests for brand Adcirca and Revatio only:

☐ Yes ☐ No Has the patient failed an adequate trial of one month of generic sildenafil?

Requests for Adempas:

☐ Yes ☐ No Is the patient concurrently on organic nitrates (e.g., *isosorbide mononitrate, isosorbide dinitrate, nitroglycerin*)?

☐ Yes ☐ No Is the patient concurrently using PDE inhibitors (e.g., sildenafil, Adcirca, dipyridamole or theophylline)?

☐ Yes ☐ No Is the patient on nitric oxide donors (e.g., amyl nitrate)?

For Primary PAH Diagnosis:

☐ Yes ☐ No Does the patient have a contraindication, intolerance, allergy or failure of an adequate trial of 1 month of Letairis, Opsumit, or Tracleer? *If yes*, please indicate: ☐ Letairis ☐ Opsumit ☐ Tracleer

☐ Yes ☐ No Does the patient have a contraindication, intolerance, allergy or failure of an adequate trial of 1 month of sildenafil, Adcirca or Revatio? *If yes*, please indicate: ☐ sildenafil ☐ Adcirca ☐ Revatio

For PAH secondary to CTEPH:

☐ Yes ☐ No Does the patient have a documented diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH) that is inoperable or has not resolved from surgery?

☐ Yes ☐ No Does the patient have a documented thromboembolic occlusion of the pulmonary vasculature?

Requests for Orenitram or Uptravi:

☐ Yes ☐ No Does the patient have severe hepatic impairment (Child Pugh Class C)?

☐ Yes ☐ No Is the patient converting from an infused or inhaled vasodilator (e.g., epoprostenol, treprostinil, or iloprost)?

☐ Yes ☐ No Will the patient be using another concurrent vasodilator (e.g., epoprostenol, treprostinil, or iloprost)?

For All Continuation Requests:

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples? (Sampling does not guarantee coverage under the provisions of the pharmacy benefit)

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.