



Ventavis® (iloprost inhalation solution) Medication Precertification Request

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

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form
GR-69250-3

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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #:	If yes, provide ID#: _____ Carrier Name: _____
Insured:	Insured:
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #:	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name:		<i>(Check One):</i> <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> 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: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____	Dispensing Provider/Pharmacy: (Patient selected choice) <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other: _____ Name: _____ Address: _____ Phone: _____ FAX: _____ TIN: _____ PIN: _____
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E. PRODUCT INFORMATION

Request is for: Ventavis (iloprost inhalation solution) 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 Initiation Requests (clinical documentation required):

Please indicate the World Health Organization (WHO) classification of pulmonary hypertension:
Select one: 1 2 3 4 5

Yes No Does the patient have a diagnosis of pulmonary arterial hypertension (PAH)?

Yes No Has PAH been confirmed by right heart catheterization at rest?

Yes No Is the patient an infant less than one year of age?

Yes No Does the patient have any of the following conditions: post cardiac surgery, chronic heart disease, chronic lung disease associated with prematurity or congenital diaphragmatic hernia?

Yes No Has Doppler echocardiogram been performed to diagnose PAH?

→ Please indicate the pretreatment mean pulmonary arterial pressure results:
 Less than 25mmHg Greater than or equal to 25 mmHg

What is the pretreatment capillary wedge pressure? Less than or equal to 15 mmHg Greater than 15 mmHg

What is the pretreatment pulmonary vascular resistance? Less than or equal to 3 Wood units Greater than 3 Wood units

For Continuation of Therapy Requests (clinical documentation required):

Yes No Is the patient experiencing benefit from therapy as evidenced by disease stability or disease improvement?

→ Please select: disease stability disease improvement

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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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.