



Request for Prior Authorization
PULMONARY ARTERIAL HYPERTENSION AGENTS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for agents used to treat pulmonary hypertension.

Preferred

- Epoprostenol, Letairis, Sildenafil, Tracleer, Ventavis

Non-Preferred

- Adcirca, Flolan, Opsumit, Remodulin, Revatio, Upravi, Veletri, Tyvaso

Strength Dosage Instructions Quantity Days Supply

Diagnosis:

- Pulmonary arterial hypertension, Other (please specify)

Reason for use of Non-Preferred drug requiring prior approval:

Other medical conditions to consider:

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.) Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only.