Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Pulmonary Hypertension Agents - Oral & Inhaled

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans 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 (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Patient Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Patient Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
HPP's maximum approval time is 12 months but may be less depending on the drug.		

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is this a request for renewal of therapy (i.e., The requested drug has been previously approved by prior authorization)?
[If YES, skip to question 26.}

☐ Yes ☐ No

Q2. Is the request for Adcirca, Alyq, Revatio, sildenafil or tadalafil (phosphodiesterase type 5 inhibitors)?

☐ Yes ☐ No

Q3. Does the member have a diagnosis of pulmonary arterial hypertension (PAH)?

☐ Yes ☐ No

Q4. Is the prescribed agent being requested for the treatment of a diagnosis that is indicated in the United States Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication?

☐ Yes ☐ No

Q5. Does the member have a diagnosis of pulmonary arterial hypertension (PAH)?

☐ Yes ☐ No

Q6. Is the requested drug appropriate for the member's level of risk based on current risk calculator assessment (e.g., REVEAL 2.0) and current medical literature?

☐ Yes ☐ No

Q7. Is the prescribed dose consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia or peer-reviewed medical literature?

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Patient Name:	Prescriber Name:

☐ Yes	☐ No
Q8. Is the patient at least 18 years of age?	
☐ Yes	☐ No
Q9. Is the requested drug prescribed by or in consultation with a pediatric pulmonologist, pediatric cardiologist or heart and lung transplant specialist skilled in treating pulmonary hypertension?	
☐ Yes	☐ No
Q10. Is the member able to access a Pulmonary Hypertension Association-accredited center?	
☐ Yes	☐ No
Q11. Is the requested drug prescribed by or in consultation with a practitioner at a Pulmonary Hypertension Association-accredited center?	
☐ Yes	☐ No
Q12. Is the requested drug prescribed by or in consultation with an appropriate specialist (e.g., pulmonologist, cardiologist or rheumatologist) skilled in treating pulmonary hypertension?	
☐ Yes	☐ No
Q13. Does the member have a history of contraindication to the prescribed medication?	
☐ Yes	☐ No
Q14. Is the diagnosis chronic thromboembolic pulmonary hypertension (CTEPH)? [If YES, skip to question 22.]	
☐ Yes	☐ No
Q15. Is the diagnosis pulmonary arterial hypertension (PAH) World Health Organization (WHO) Group 1?	
☐ Yes	☐ No
Q16. Does the member have a right heart catheterization indicating all of the following hemodynamic values: A) Mean pulmonary arterial pressure greater than 20 millimeters of mercury, B) Pulmonary capillary wedge pressure, left atrial pressure or left ventricular end-diastolic pressure less than or equal to 15 millimeters of mercury, C) Pulmonary vascular resistance greater than or equal to 3 Wood units? [Note: Please attach documentation.]	
☐ Yes	☐ No
Q17. Does the member have idiopathic pulmonary arterial hypertension (PAH)? [If YES, skip to question 23.	
☐ Yes	☐ No

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Q18. Has the member undergone acute vasoreactivity testing?
[Note: Please attach chart documentation.]

☐ Yes ☐ No

Q19. Does the member have a contraindication to vasoreactivity testing or increased risk of adverse events during acute vasoreactivity testing (e.g., high risk stratification based on current risk calculator assessment (REVEAL 2.0), low systemic blood pressure, low cardiac index or pulmonary veno-occlusive disease)?

☐ Yes ☐ No

Q20. Do the results of the testing demonstrate acute vasoreactivity?

☐ Yes ☐ No

Q21. Has the member had therapeutic failure with or a contraindication or intolerance to calcium channel blockers (i.e., amlodipine, nifedipine or diltiazem)?
[Note: Please attach documentation.]

☐ Yes ☐ No

Q22. Does the member have both of the following hemodynamic values from right heart catheterization:
A) Mean pulmonary arterial pressure greater than 20 millimeters of mercury, AND
B) Pulmonary vascular resistance greater than or equal to 3 Wood units?
[Note: Please attach documentation.]

☐ Yes ☐ No

Q23. Does the member have one of the following:
A) a H2FPEF score less than 2
B) a left atrial volume index less than 35 mL/m2
C) a negative provocative test in a heart catheterization lab (fluid challenge with pulmonary capillary wedge pressure, left atrial pressure, or left ventricular end-diastolic pressure less than or equal to 17 mmHG?

☐ Yes ☐ No

Q24. Is the request for a non-preferred pulmonary arterial hypertension (PAH) agent, oral and inhaled?

☐ Yes ☐ No

Q25. Does the member have a history of therapeutic failure, contraindication or intolerance to the preferred pulmonary arterial hypertension (PAH) agents approved or medically accepted for the member's diagnosis or indication?

☐ Yes ☐ No

Q26. Does the member have a current history (within the past 90 days) of being prescribed the same non-preferred pulmonary arterial hypertension (PAH) agent, oral and inhaled?

☐ Yes ☐ No

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Q27. Based on the prescriber's assessment, is there documentation of tolerability and a continued benefit from the requested drug?

☐ Yes ☐ No

Q28. Is the prescribed dose consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia or peer-reviewed medical literature?

☐ Yes ☐ No

Q29. Is the member at least 18 years old?

☐ Yes ☐ No

Q30. Is the member able to access a Pulmonary Hypertension Association-accredited center?

☐ Yes ☐ No

Q31. Is the requested drug prescribed by or in consultation with a practitioner at a Pulmonary Hypertension Association-accredited center?

☐ Yes ☐ No

Q32. Is the requested drug prescribed by or in consultation with an appropriate specialist (e.g., pulmonologist, cardiologist or rheumatologist)?

☐ Yes ☐ No

Q33. Is the requested drug prescribed by or in consultation with a pediatric pulmonologist, pediatric cardiologist or heart and lung transplant specialist?

☐ Yes ☐ No

Q34. Does the member have a history of contraindication to the prescribed drug?

☐ Yes ☐ No

Q35. Additional Information:

_____ _____

Prescriber Signature Date

Updated for 2023