PULMONARY ANTIHYPERTENSIVES PRIOR AUTHORIZATION REQUEST FORM

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Optum Rx®

United Healthcare Community Plan

Today's Date
☐☐ / ☐☐ / ☐☐☐☐

Note: This form must be completed by the prescribing provider.

****All sections must be completed or the request will be returned****

Patient's Medicaid # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Prescriber's Signature
Return Fax # ☐☐☐ - ☐☐☐ - ☐☐☐☐	Return Phone # ☐☐☐ - ☐☐☐ - ☐☐☐☐
Check box if requesting retro-active PA ☐	Date(s) of service requested for retro-active eligibility (if applicable):

Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

Requested Medication	Strength	Quantity	Dosage Regimen

General information applicable to all products:

Pulmonary Antihypertensive PA Requirements for ALL agents:

1. Member has a diagnosis of pulmonary arterial hypertension ☐ Yes ☐ No
2. Member has a diagnosis of pulmonary hypertension associated with interstitial lung disease (only applicable to Tyvaso/Tyvaso DPI or Yutrepia DPI) ☐ Yes ☐ No
3. Member has a diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH) (only applicable to Adempas) ☐ Yes ☐ No
4. Requested agent has been prescribed by, or in consultation with, a pulmonologist or cardiologist ☐ Yes ☐ No

Product specific information:

If the request is for Adempas (riociguat):

1. For those of childbearing potential, a negative pregnancy test obtained in the past 30 days has been submitted ☐ Yes ☐ No ☐ Not applicable to member
   Date of negative pregnancy test (include documentation): _____
2. Member is currently receiving one of the following: nitrate therapy, PDE5 inhibitor, nonspecific PDE inhibitor (dipyridamole; theophylline; aminophylline), vericiguat ☐ Yes ☐ No
3. Member is enrolled in the riociguat REMS program if meeting eligibility requirement
   ☐ Yes ☐ No ☐ Not applicable to member
4. Dose requested is 7.5mg per day or less ☐ Yes ☐ No

   If no, please explain:_____

If the request is for Adcirca (tadalafil):

1. Member is currently receiving one of the following: nitrate therapy, PDE-5 inhibitor (other than the one being requested), riociguat ☐ Yes ☐ No
2. Dose requested is 40 mg per day or less ☐ Yes ☐ No

Note: 'Alyq' requires trial and failure of generic tadalafil or medical justification for use

If the request is for Letairis (ambrisentan):

1. For those of childbearing potential, a negative pregnancy test obtained in the past 30 days has been submitted ☐ Yes ☐ No ☐ Not applicable to member
   Date of negative pregnancy test (include documentation): _____
2. Member is currently receiving cyclosporine therapy (requires dose reduction) ☐ Yes ☐ No
   Note: dose of Letairis (ambrisentan) must be adjusted to max: 5 mg/day
3. Member has had a previous trial and failure of Tracleer (bosentan) ☐ Yes ☐ No
   If no, please explain_____
4. Dose requested is 10 mg per day or less ☐ Yes ☐ No

If the request is for Opsumit (macitentan):

1. For those of childbearing potential, a negative pregnancy test obtained in the past 30 days has been submitted ☐ Yes ☐ No ☐ Not applicable to member
   Date of negative pregnancy test (include documentation): _____
2. Member has had a previous trial and failure of Tracleer (bosentan) ☐ Yes ☐ No
   If no, please explain_____
3. Dose requested is 10 mg per day or less ☐ Yes ☐ No

If the request is for Opsynvi (macitentan/tadalafil):

1. For those of childbearing potential, a negative pregnancy test obtained in the past 30 days has been submitted ☐ Yes ☐ No ☐ Not applicable to member
   Date of negative pregnancy test (include documentation): _____
2. Member has had a previous trial and failure of separate components (macitentan & tadalafil) ☐ Yes ☐ No
   If no, please explain_____
3. Member is currently receiving one of the following: nitrate therapy, PDE-5 inhibitor (other than the one being requested), riociguat ☐ Yes ☐ No
4. Dose requested is 10 mg/40 mg per day or less ☐ Yes ☐ No

If the request is for Orenitram (treprostinil):

1. Does the member have severe hepatic impairment (Child-Pugh class C)? ☐ Yes ☐ No
   Note: members with Child-Pugh class C hepatic impairment will be denied; Orenitram titration packs will be limited to 1 pack per 90 days

If the request is for Revatio (sildenafil) tablets or injection:

1. Member is currently receiving one of the following: nitrate therapy, riociguat, atazanavir, darunavir, fosamprenavir, indinavir, lopinavir/ritonavir, nelfinavir, ritonavir, saquinavir, tipranavir, PDE-5 inhibitor (other than the one being requested) ☐ Yes ☐ No
2. Dose requested is 60 mg per day or less ☐ Yes ☐ No

If the request is for sildenafil oral suspension:

1. Member is under 12 years of age ☐ Yes ☐ No
2. Member is unable to swallow tablet formulation ☐ Yes ☐ No
3. Member is currently receiving one of the following: nitrate therapy, riociguat, atazanavir, darunavir, fosamprenavir, indinavir, lopinavir/ritonavir, nelfinavir, ritonavir, saquinavir, tipranavir, PDE-5 inhibitor (other than the one being requested) ☐ Yes ☐ No
4. Dose requested is 60 mg per day or less ☐ Yes ☐ No

If the request is for Tadliq (tadalafil) oral suspension:

1. Member is under 12 years of age ☐ Yes ☐ No
2. Member is unable to swallow tablet formulation ☐ Yes ☐ No
3. Member is currently receiving one of the following: nitrate therapy, PDE-5 inhibitor (other than the one being requested), riociguat ☐ Yes ☐ No
4. Dose requested is 40 mg per day or less ☐ Yes ☐ No
5. Select one of the following:
   - Member has had a previous trial and failure of sildenafil oral suspension ☐ Yes ☐ No

     If no, please explain

     _____

     _____

- Member requires Tadliq (tadalafil) as a less frequent dosing option (chart documentation must be submitted) ☐ Yes ☐ No

If the request is for Tracleer (bosentan):

Request is for:
☐ Tracleer (bosentan) tablet
☐ Tracleer (bosentan) dispersible tablet*

****(Note: plan prefers brand name Tracleer dispersible tablet; requests for generic bosentan dispersible tablet will require generic medically necessary PA review)***

1. Member is enrolled in the bosentan REMS program (***Note**: ALL members **must** be enrolled in the bosentan REMS program)* ☐ Yes ☐ No
2. For those of childbearing potential, a negative pregnancy test obtained in the past 30 days has been submitted ☐ Yes ☐ No ☐ Not applicable to member
   Date of negative pregnancy test (include documentation): _____
3. Will the member be utilizing cyclosporine-A or glyburide therapy concurrently with bosentan?
   ☐ Yes ☐ No
   Note: members planning to use cyclosporine-A or glyburide concurrently with bosentan will be denied
4. Member age: _____ weight: _____ LB/KG (circle one)
5. Does the requested dose exceed 250mg per day OR dose limits based on age/weight listed in criteria? ☐ Yes ☐ No
   If yes, please explain: _____

If the request is for Uptravi (selexipag):

1. Member has had a previous trial and failure of Orenitram (treprostinil) ☐ Yes ☐ No
   If no, please explain_____
2. Will the member be utilizing a CYP2C8 inhibitor (e.g., gemfibrozil) concurrently with selexipag? ☐ Yes ☐ No
   Note: members planning to use CYP2C8 inhibitors concurrently with selexipag will be denied

If the request is for Winrevair (sotarcept-csrk)

1. Member is 18 years of age or older ☐ Yes ☐ No ☐
2. Member has had a previous trial and failure of at least 60 days of therapy with any agent from TWO of the following subcategories: endothelin receptor antagonists, phosphodiesterase 5-inhibitors, prostacyclin receptor modulators, or soluble guanylate cyclase inhibitor ☐ Yes ☐ No

   If yes, please list each agent and dates of trial (start and stop dates, if therapy is ongoing indicate as such):
   - Endothelin receptor antagonist:

- Medication name: _____
- Dates of trial:_____

- Phosphodiesterase 5-inhibitor:
  - Medication name: _____
  - Dates of trial:_____
- Prostacyclin receptor modulator:
  - Medication name: _____
  - Dates of trial:_____
- Soluble guanylate cyclase inhibitor:
  - Medication name: _____
  - Dates of trial:_____

If no, please explain_____

3. Member's actual body weight: _____ LB/KG (circle one)
   a. Does the requested dose exceed 0.7 mg/kg every 3 weeks? ☐ Yes ☐ No

      If yes, please explain:

      _____

4. Prescriber attests to all of the following:
   a. Prescriber has obtained baseline hemoglobin and platelet count prior to initiating therapy ☐ Yes ☐ No
   b. Baseline platelet count is 50,000/mm^3 (50 x 10^6/L) or greater ☐ Yes ☐ No
   c. Prescriber will continue to monitor hemoglobin and platelet count and adjust dosing per the prescribing information ☐ Yes ☐ No

If the request is for Yutrepia (treprostinil) DPI:

1. Member has had a previous trial and failure of Tyvaso (treprostinil) DPI ☐ Yes ☐ No
   If no, please explain:

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