UnitedHealthcare Community Plan

Pulmonary Arterial Hypertension - Arizona
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
NPI #:	Phone:	Fax:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

UnitedHealthcare Community Plan

Pulmonary Arterial Hypertension - Arizona
Prior Authorization Request Form

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS:

- **What is the patient's diagnosis? □ Yes □ No (Check which apply)**
  - □ Pulmonary Arterial Hypertension
  - □ Inoperable or Persistent/Recurrent Chronic Thromboembolic Pulmonary Hypertension (CTEPH)
  - □ Other, list diagnosis: _____

- **Does the patient have a diagnosis of symptomatic pulmonary arterial hypertension? □ Yes □ No**

- **Has the patient's diagnosis of PAH been confirmed by right heart catheterization? □ Yes □ No**

- **Does the patient have a history of failure, contraindication or intolerance to sildenafil citrate tablets (generic Revatio)? □ Yes □ No**
  (If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- **If requesting Revatio (brand), is there documentation the patient is receiving clinical benefit to this therapy?**
  □ Yes □ No If yes, list clinical benefit: _____
  _____

Requests for ADCIRCA – ORENITRAM - UPTRAVI:

- **Is the patient currently on any therapy for the diagnosis of pulmonary arterial hypertension?**
  If yes, list therapy: _____

- **Does the patient have a history of failure, contraindication or intolerance to one of the following: □ Yes □ No (check all that apply)**
  □ A PDE-5 inhibitor [e.g. sildenafil citrate (generic Revatio), Adcirca or Revatio] □ Adempas
  (If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- **Does the patient have a history of failure, contraindication or intolerance to an ERA (e.g., Letairis, Opsumit or Tracleer)? □ Yes □ No**
  (If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- **Is the patient using Orenitram in combination with a prostanoid/prostacyclin analogue (e.g., epoprostenol, iloprost, treprostinil) as long-term concomitant therapy? □ Yes □ No**
  If yes, list medication: _____

- **Is the patient taking Uptravi in combination with a prostanoid/prostacyclin analogue (e.g., epoprostenol, iloprost, treprostinil)? □ Yes □ No**
  If yes, list medication: _____

Requests for CONTINUATION OF THERAPY FOR ADCIRCA – ORENITRAM - UPTRAVI:

- **Is the patient receiving a documented clinical benefit to therapy? □ Yes □ No**
  If yes, list response: _____
  _____

- **Is the patient taking the requested medication in combination with a prostanoid/prostacyclin analogue (e.g., epoprostenol, iloprost, treprostinil)?**
  If yes, list medication: _____

Provider Signature: _____ **Date:** _____