MEDICARE FORM

Pulmonary Hypertension (Inhalation or Injectable Medication) Precertification Request

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

For Ohio MMP:
FAX: 1-855-734-9389
PHONE: 1-855-364-0974

For other lines of business:
Please use other form.

Note: Remodulin, Flolan, and Veletri are non-preferred. The preferred products are generic treprostinil and epoprostenol injectables. Generic treprostinil injectable does not require precertification. Generic epoprostenol injectable requires precertification.

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 #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

C. PRESCRIBER INFORMATION

First Name:	Last Name:			*(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.	
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Office Contact Name:				Phone:	

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office ☐ Home
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy:
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: ☐ epoprostenol injection ☐ Flolan (epoprostenol injection) ☐ Remodulin (treprostinil injection) ☐ Revatio (sildenafil injection)
☐ Tyvaso (treprostinil inhalation solution) ☐ Veletri (epoprostenol injection) ☐ Ventavis (iloprost inhalation solution)

Dose: _____ **Frequency:** _____
HCPCS Code: _____ ☐ Implantable infusion pump ☐ External infusion pump ☐ IV ☐ SC

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 All Requests (clinical documentation required):

Note: Remodulin, Flolan, and Veletri are non-preferred. The preferred products are generic treprostinil and epoprostenol injectables. Generic treprostinil injectable does not require precertification. Generic epoprostenol injectable requires precertification.

☐ Yes ☐ No Has the patient had prior therapy with Remodulin (treprostinil injection), Flolan (epoprostenol injectable), or Veletri (epoprostenol injectable) within the last 365 days?

☐ Yes ☐ No Has the patient had a trial, intolerance, or contraindication to generic treprostinil or epoprostenol injection?

☐ Yes ☐ No Does the patient have a diagnosis of Raynaud's phenomenon?

Please explain if there are any other medical reason(s) that the patient cannot use generic treprostinil or epoprostenol injection:

_____

_____

Please indicate the severity of the patient's symptoms using the World Health Organization (WHO) functional classification system:
Select one: ☐ I ☐ II ☐ III ☐ IV

☐ Yes ☐ No Was the mean pulmonary artery pressure documented by right heart catheterization or echocardiography?
→ Please indicate test and results: ☐ Echocardiography ☐ Right heart catheterization
At rest: _____ mmHg With exertion: _____ mmHg

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

☐ Yes ☐ No Does the patient have a diagnosis of pulmonary hypertension?
→ Please identify the type of pulmonary hypertension:

☐ Chronic thromboembolic pulmonary hypertension (CTEPH) ☐ Hereditary PAH due to activin receptor-like kinase type 1 (ALK1),endoglin, mothers against decapentaplegic 9 (SMAD9), caveolin-1 (CAV1), or potassium channel subfamily K member-3 (KCNK3) ☐ Hereditary PAH due to bone morphogenetic protein receptor type 2 (BMPR2) ☐ Hereditary PAH due to unknown causes ☐ Idiopathic PAH (formerly primary pulmonary hypertension) ☐ PAH due to diseases that localize to small pulmonary arterioles, including drug and toxin-induced (e.g., anorectic agents (diet drugs)) ☐ PAH associated with congenital heart disease ☐ PAH associated with connective tissue diseases ☐ PAH associated with HIV infection ☐ PAH associated with portal hypertension ☐ PAH associated with schistosomiasis ☐ Persistent pulmonary hypertension of the newborn (PPHN) (such as associated with congenital diaphragmatic hernia) ☐ Pulmonary hypertension associated with pulmonary veno-occlusive disease (PVOD) or pulmonary capillary hemangiomatosis (PCH) ☐ Sarcoidosis associated with pulmonary hypertension ☐ Other:_____

☐ Yes ☐ No ☐ **N/A** Has the patient undergone an acute vasoreactivity test prior to initiation of therapy?
→ ☐ Yes ☐ No Is an acute vasoreactivity test contraindicated due to right heart failure, low systemic blood pressure, low cardiac index, or presence of severe (functional class IV) symptoms?
→ Please select: ☐ Low cardiac index ☐ Low systemic blood pressure ☐ Right heart failure ☐ Severe functional class IV symptoms

→ ☐ Yes ☐ No Did the patient have a **positive** acute vasoreactivity test result (defined as a decrease in mPAP (mean pulmonary artery pressure) at least 10 mmHg to an absolute level of less than 40 mgHg without a decrease in cardiac output)?
→ ☐ Yes ☐ No Does the patient have a documented trial and failure of a calcium channel blocker (dihydropyridine or diltiazem)?
→ ☐ Yes ☐ No Does the patient have a contraindication to a calcium channel blocker (e.g., right heart failure, hemodynamic instability)?

For Initiation Requests (clinical documentation required):

Revatio (sildenafil injection)

☐ Yes ☐ No Is the patient concurrently on organic nitrates (e.g., isosorbide mononitrate, isosorbide dinitrate, nitroglycerin)?
☐ Yes ☐ No Is the patient concurrently on guanylate cyclase (GC) stimulators (e.g., Adempas (riociguat))?

For Continuation of Therapy Requests (clinical documentation required):

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples?
☐ Yes ☐ No Is there clinical documentation indicating disease stability or improvement?
→ Please select: ☐ Disease stability ☐ Disease improvement

For Revatio (sildenafil injection) only:

☐ Yes ☐ No Is the patient concurrently on organic nitrates (e.g., isosorbide mononitrate, isosorbide dinitrate, nitroglycerin)?
☐ Yes ☐ No Is the patient concurrently on guanylate cyclase (GC) stimulators (e.g., Adempas (riociguat))?

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.