



FAX Completed Form To
 1.877.386.4695
Provider Help Desk
 1.866.399.0928

**Request for Prior Authorization
 PULMONARY ARTERIAL HYPERTENSION AGENTS**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID # _ _ _ _ _ _ _ _ _ _ _ _ _ _	Patient name	DOB
Patient address		
Provider NPI _ _ _ _ _ _ _ _ _ _ _ _ _ _	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI _ _ _ _ _ _ _ _ _ _ _ _ _ _	Pharmacy fax	NDC _ _ _ _ _ _ _ _ _ _ _ _ _ _

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

Preferred

Non-Preferred

- | | | | | | | |
|---------------------------------------|------------------------------------|-----------------------------------|-----------------------------------|------------------------------------|--|----------------------------------|
| <input type="checkbox"/> Ambrisentan | <input type="checkbox"/> Tadalafil | <input type="checkbox"/> Adcirca | <input type="checkbox"/> Flolan | <input type="checkbox"/> Orenitram | <input type="checkbox"/> Sildenafil Susp | <input type="checkbox"/> Tyvaso |
| <input type="checkbox"/> Epoprostenol | <input type="checkbox"/> Tracleer | <input type="checkbox"/> Adempas | <input type="checkbox"/> Letairis | <input type="checkbox"/> Remodulin | <input type="checkbox"/> Tracleer SolTab | <input type="checkbox"/> Upravi |
| <input type="checkbox"/> Sildenafil | <input type="checkbox"/> Ventavis | <input type="checkbox"/> Bosentan | <input type="checkbox"/> Opsumit | <input type="checkbox"/> Revatio | <input type="checkbox"/> Trepostinil | <input type="checkbox"/> Veletri |

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
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IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.