



MEDICARE FORM

Pulmonary Hypertension (Inhalation or Injectable Medication) Precertification Request

Page 1 of 2

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

Virginia (HMO D-SNP):
FAX: 1-833-280-5224
PHONE: 1-855-463-0933

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 #:	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #:	If yes, provide ID#: _____ Carrier Name: _____
Insured:	Insured:

C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> 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: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Home <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____	Dispensing Provider/Pharmacy: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other: _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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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
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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 (BMP2) 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 mmHg 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.