

INDIANA HEALTH COVERAGE PROGRAMS (IHCP)
PULMONARY ANTIHYPERTENSIVES PRIOR AUTHORIZATION REQUEST FORM



MDwise
Fax to: (858) 790-7100
c/o MedImpact Healthcare Systems, Inc.
Attn: Prior Authorization Department
10181 Scripps Gateway Court, San Diego, CA 92131
Phone: (808) 788-2949



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 # <input type="text"/>	Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/>
Patient's Name	Prescriber's Name
Prescriber's IN License # <input type="text"/>	Specialty
Prescriber's NPI # <input type="text"/>	Prescriber's Signature
Return Fax # <input type="text"/> - <input type="text"/> - <input type="text"/>	Return Phone # <input type="text"/> - <input type="text"/> - <input type="text"/>
Check box if requesting retro-active PA <input type="checkbox"/>	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 hypertension ☐ Yes ☐ No
2. Member has a diagnosis of pulmonary hypertension associated with interstitial lung disease (only applicable to Tyvaso/Tyvaso 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. Requested dose 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. Member is enrolled in the ambrisentan or PS-ambrisentan REMS program if meeting eligibility requirement ☐ Yes ☐ No ☐ Not applicable to member
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. Member is currently receiving cyclosporine therapy (requires dose reduction) ☐ Yes ☐ No
Note: dose of Letairis (ambrisentan) must be adjusted to max: 5 mg/day
4. Member has had a previous trial and failure of Tracleer (bosentan) ☐ Yes ☐ No
If no, please explain: _____
5. Dose requested is 10 mg per day or less ☐ Yes ☐ No

If the request is for Liqrev (sildenafil) oral suspension:

1. Member is 18 years of age or older ☐ 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
5. Member has had a previous trial and failure of sildenafil suspension ☐ Yes ☐ No
If no, please explain: _____

If the request is for Opsumit (macitentan):

1. Member is enrolled in the macitentan REMS program if meeting eligibility requirement
☐ Yes ☐ No ☐ Not applicable to member
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. 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 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 Revatio (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. Member has had a previous trial and failure of sildenafil oral suspension ☐ Yes ☐ No
If no, 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 Tracleer (bosentan):

Request is for:

- ☐ Tracleer tablet
☐ Tracleer dispersible tablet
☐ bosentan tablet*

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: _____

Note: Tracleer tablets are brand preferred. Authorization for generic bosentan tablets is contingent upon medical necessity for use instead of the branded agent.

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