### Pulmonary Arterial Hypertension (PAH)

ambrisentan (Letairis®), macitentan (Opsumit®), bosentan (Tracleer®), epoprostenol (Flolan®, Veletri®), treprostinil (Tyvaso®, Remodulin®, Orenitram®), Selexipag (Uptravi®), iloprost (Adcirca®)

**PRIOR AUTHORIZATION REQUEST FORM**

For authorization, please answer each question, include patient chart notes to document clinical information, and fax this form back to the U of U Health Plans Prior Authorization Department at 844-316-6544.

If you have prior authorization questions, please call assistance: Healthy U: 866-236-5935, University of Utah Health Employees: 866-861-6178, Individual Exchange: 866-236-5936, Commercial Groups: 866-236-5930

#### Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Yes</th>
<th>No</th>
<th>Comments/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the member have a diagnosis of Pulmonary Arterial Hypertension (PAH)?</td>
<td>☐</td>
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<tr>
<td>2. Is the member classified as WHO (World Health Organization) Group 1 pulmonary arterial hypertension? If not, please provide the WHO group classification.</td>
<td>☐</td>
<td>☐</td>
<td>Please provide documentation</td>
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<tr>
<td>3. Is the requesting provider a cardiologist or pulmonologist specializing in pulmonary hypertension?</td>
<td>☐</td>
<td>☐</td>
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<td>4. Has the member shown to be at least 75% compliant with provider visits in the past 12 months?</td>
<td>☐</td>
<td>☐</td>
<td>Please provide documentation</td>
</tr>
<tr>
<td>5. Has the member demonstrated at least 80% compliance with pulmonary hypertension medications?</td>
<td>☐</td>
<td>☐</td>
<td>Please provide documentation</td>
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<tr>
<td>6. If the member has a positive vasoreactivity test, have they had a trial and failure of oral calcium channel blocker therapy with dihydropyridine or diltiazem?</td>
<td>☐</td>
<td>☐</td>
<td>Please provide documentation</td>
</tr>
<tr>
<td>7. Has the patient undergone a urine drug screening?</td>
<td>☐</td>
<td>☐</td>
<td>Please provide documentation</td>
</tr>
</tbody>
</table>

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7/1/2019
8. Is the patient currently smoking tobacco?  
   ☐  ☐  

9. Has the patient performed a baseline 6-minute walk test?  
   ☐  ☐  
   Please provide documentation

### Phosphodiesterase-5 Inhibitors
- **sildenafil, tadalafil**

1. If the request is for sildenafil solution (Revatio) or injection, is the member less than 6 years or age, unable to swallow tablets, and/or unable to take any medication by mouth?  
   ☐  ☐  
   Please provide documentation

2. If the request is for tadalafil, has the member had a 3-month trial and failure of sildenafil with at least 1 month at the maximum tolerated dose?  
   ☐  ☐  
   Please provide documentation

### Endothelin Receptor Antagonists – ambrisentan (Letairis®), macitentan (Opsumit®), bosentan (Tracleer®)

1. If the request is for ambrisentan, bosentan or macitentan, will it be used in combination with a phosphodiesterase inhibitor?  
   ☐  ☐  
   Please provide documentation

2. If the request is for bosentan or macitentan, has ambrisentan been trialed and failed?  
   ☐  ☐  
   Please provide documentation

### Prostacyclin Pathway Agonists
- **epoprostenol (Flolan®, Veletri®), Treprostinil (Tyvaso®, Remodulin®, Orenitram®), Selexipag (Uptravi®), iloprost (Ventavis®)**

- Do any of the following apply:
  a. Has the member tried and failed combination treatment with a PDE5 inhibitor (such as sildenafil or tadalafil) with ambrisentan?  
     ☐  ☐  
     Please provide documentation
  b. Is the member in WHO functional class III with clinical documentation showing rapid progression or have other markers of poor clinical prognosis?  
  c. Is the member in WHO functional class IV?  

### Guanylate Cyclase Stimulator: Riociguat (Adempas®)

1. Is the member in WHO functional class II, III, or IV?  
   ☐  ☐  
   Please provide documentation

2. If the member has a clinical diagnosis of WHO group 1, have they tried and failed combination therapy with a PDE5 inhibitor (such as sildenafil or tadalafil) with ambrisentan?  
   ☐  ☐  
   Please provide documentation

1. Does the member have a clinical diagnosis of WHO Group 4 PAH after surgical treatment OR have confirmed inoperable chronic thromboembolic pulmonary?  
   ☐  ☐  
   Please provide documentation

### REAUTHORIZATION

1. Does documentation show disease improvement or stabilization (e.g. improvement in 6 minute walk test, functional class, pulmonary arterial pressure, cardiac index, etc.)?  
   ☐  ☐  
   Please provide documentation

Additional information:

Physician’s Signature:

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