pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

PULMONARY HYPERTENSION AGENTS, ORAL AND INHALED

PRIOR AUTHORIZATION FORM *(form effective 1/3/2022)*

Prior authorization guidelines for **Pulmonary Hypertension Agents, Oral and Inhaled** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug name:	Strength:	Formulation:	
Dose/directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	
Has the beneficiary been taking the requested medication within the past 90 days?		☐Yes ☐No	*Submit documentation of drug regimen and clinical response.*
Is the requested medication prescribed by or in consultation with a practitioner at a Pulmonary Hypertension Association-accredited center or other specialist skilled in treating pulmonary hypertension?		☐Yes ☐No	*Submit documentation of consultation, if applicable.*

INITIAL requests

For a non-preferred Pulmonary Hypertension Agent: Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred agents in this class that are approved or medically accepted for treatment of the beneficiary's condition? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred agents in this class.*	☐Yes ☐No	*Submit documentation.*

Complete the sections below that are applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐**For treatment of PAH (WHO Group 1):**

- ☐The requested medication is appropriate for the beneficiary's level of risk based on a current risk calculator assessment (e.g., REVEAL 2.0) and current medical literature
- ☐Had a right heart catheterization showing the following:
  - ☐A mean pulmonary arterial pressure greater than 20 mmHg
  - ☐A pulmonary capillary wedge pressure, left atrial pressure, or left ventricular end-diastolic pressure less than or equal to 15 mmHg
  - ☐A pulmonary vascular resistance greater than or equal to 3 Wood units

☐**Also, for idiopathic PAH:**

- ☐Has an H_2FPEF score less than 2
- ☐Has a left atrial volume index less than 35 mL/m^2
- ☐Has a negative provocative test in a heart catheterization lab (fluid challenge with pulmonary capillary wedge pressure, left atrial pressure, or left ventricular end-diastolic pressure less than or equal to 17 mmHg)
- ☐Has chart documentation of acute vasoreactivity testing

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

☐ Has a medical reason for not having vasoreactivity testing
- ☐ High risk stratification based on current risk calculator assessment (e.g., REVEAL 2.0)
- ☐ Low systemic blood pressure
- ☐ Low cardiac index
- ☐ Pulmonary veno-occlusive disease
- ☐ Other *(describe)*: _____

☐ Demonstrates acute vasoreactivity
- ☐ Has a history of trial and failure of or contraindication or intolerance to calcium channel blockers

☐ **For treatment of CTEPH:**
- ☐ Has a mean pulmonary arterial pressure greater than 20 mmHg
- ☐ Has a pulmonary vascular resistance greater than or equal to 3 Wood units

RENEWAL requests

Does the beneficiary continue to benefit from the requested medication?	☐ Yes ☐ No *Submit documentation of clinical response.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: