



# MEDICARE FORM

## Pulmonary Hypertension (Inhalation or Injectable Medication) Precertification Request

Page 1 of 2

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

For Virginia HMO 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:			Dispensing Provider/Pharmacy:		
<input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Home			<input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy		
<input type="checkbox"/> Outpatient Infusion Center Phone: _____			<input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other: _____		
Center Name: _____			Name: _____		
<input type="checkbox"/> Home Infusion Center Phone: _____			Address: _____		
Agency Name: _____			Phone: _____ Fax: _____		
<input type="checkbox"/> Administration code(s) (CPT): _____			TIN: _____ PIN: _____		
Address: _____					
E. PRODUCT INFORMATION					
Request is for: <input type="checkbox"/> epoprostenol injection <input type="checkbox"/> Flolan (epoprostenol injection) <input type="checkbox"/> Remodulin (treprostinil injection) <input type="checkbox"/> Revatio (sildenafil injection)					
<input type="checkbox"/> Tyvaso (treprostinil inhalation solution) <input type="checkbox"/> Veletri (epoprostenol injection) <input type="checkbox"/> Ventavis (iloprost inhalation solution)					
Dose: _____		Frequency: _____			
HCPCS Code: _____		<input type="checkbox"/> Implantable infusion pump <input type="checkbox"/> External infusion pump <input type="checkbox"/> IV <input type="checkbox"/> SC			
F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.					
Primary ICD Code: <input type="checkbox"/> _____		<input type="checkbox"/> Other: _____			
G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.					
<b>For All Requests (clinical documentation required):</b>					
<b>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.</b>					
<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had prior therapy with Remodulin (treprostinil injection), Flolan (epoprostenol injectable), or Veletri (epoprostenol injectable) within the last 365 days?					
<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had a trial, intolerance, or contraindication to generic treprostinil or epoprostenol injection?					
<input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV					
<input type="checkbox"/> Yes <input type="checkbox"/> No Was the mean pulmonary artery pressure documented by right heart catheterization or echocardiography?					
↳ Please indicate test and results: <input type="checkbox"/> Echocardiography <input type="checkbox"/> 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.