Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Uptravi - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is Uptravi being prescribed by or in consultation with a cardiologist or pulmonologist?

☐ Yes ☐ No

Q2. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q3. Does the patient have a diagnosis of World Health Organization (WHO) group 1 pulmonary arterial hypertension (PAH)?

☐ Yes ☐ No

Q4. Has the diagnosis of PAH been confirmed by a complete right catheterization (RHC) (please attach RHC report)? PAH is defined as: I. A mean pulmonary arterial pressure (mPAP) greater than 20 mmHg; II. A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg; III. A pulmonary vascular resistance (PVR) greater than 3 Wood units

☐ Yes ☐ No

Q5. Does the patient have a World Health Organization (WHO) functional class of: II (Slight limitation of physical activity but comfortable at rest. Ordinary physical activity causes undue dyspnea or fatigue, chest pain, or near syncope), or III (Marked limitation of physical activity and comfortable at rest. Less than ordinary activity causes undue dyspnea or fatigue, chest pain, or near syncope)?

☐ Yes ☐ No

Q6. Are pharmacy records or chart notes provided documenting trial of or inadequate response to two of the following alternatives (used alone or in combination): I. Endothelin Receptor Antagonists (bosentan, ambrisentan, macitentan);

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II. Phosphodiesterase-5 inhibitors (sildenafil, tadalafil); III. Guanylate Cyclase stimulators (riociguat)?

☐ Yes ☐ No

Q7. Is there a treatment plan?

☐ Yes ☐ No

Q8. Will Uptravi be used along with a strong CYP2C8 inhibitor (eg gemfibrozil)?

☐ Yes ☐ No

Q9. Does the patient have hepatic impairment (Child Pugh class B or greater) with lab monitoring and dose adjustments as needed?

☐ Yes ☐ No

Q10. Additional Information:

Q11. Duration:

☐ 12 months ☐ Other:

_____ _____

Prescriber Signature Date

2023 Medicare Prior Authorization Request