Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Opsumit - 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 the prescriber a cardiologist or pulmonologist?

☐ Yes ☐ No

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

☐ Yes ☐ No

Q3. Is the patient a female?
If No, go to 8.

☐ Yes ☐ No

Q4. Is the patient pregnant?

☐ Yes ☐ No

Q5. Is the patient able to get pregnant?

☐ Yes ☐ No

Q6. Will the patient use two reliable forms of contraception during treatment and for one month after treatment?

☐ Yes ☐ No

Q7. Will the patient have pregnancy tests before therapy is initiated, monthly during therapy, and for one month after discontinuation?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q8. Does the patient have a diagnosis of World Health Organization (WHO) group 1 pulmonary arterial hypertension (PAH)?

☐ Yes ☐ No

Q9. Has the diagnosis of PAH been confirmed by a complete right heart catheterization (RHC) (please attach RHC report)? PAH defined as:
A. A mean pulmonary artery pressure (mPAP) greater than 20 mmHg
B. A pulmonary capillary wedge Pressure/ left atrial pressure/left ventricular end-diastolic pressure (PCWP/LAP/LVEDP) less than or equal to 15 mmHg
C. A pulmonary vascular resistance (PVR) greater than 3 Wood units.

☐ Yes ☐ No

Q10. 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

Q11. Will the patient’s liver enzymes, hemoglobin, and hematocrit levels be monitored at baseline prior to treatment initiation, after the first month of treatment, and then as clinically appropriate?

☐ Yes ☐ No

Q12. Requested Duration:

☐ 12 Months

Q13. Additional Information:

Prescriber Signature

Date

2023 Medicare Prior Authorization Request

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