Request for Prior Authorization — Pulmonary Hypertensives

Indiana | Anthem Blue Cross and Blue Shield | Serving Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging

Contains confidential patient information

Complete this form in its entirety and fax to the Prior Authorization of Benefits Center at: **844-864-7860** (retail) or **888-209-7838** (medical injectable).

For questions, please contact:

- Provider Help Desk: **866-408-6132** (Hoosier Healthwise)
- **844-533-1995** (Healthy Indiana Plan)
- **844-284-1798**(HoosierCareConnect)
- **833-569-4739** (Indiana PathWays for Aging)

Today's date

Month	Day	Year

Note: This form must be completed by the prescribing provider.

All sections must be completed or the request will be returned.

Patient Medicaid #:	Date of birth:
Patient name:	Prescriber's name:
Prescriber's IN license #:	Specialty:
Prescriber's NPI #:	Prescriber's signature:
Return fax #:	Return phone #:
Mark box if requesting retroactive PA: ☐	Date(s) of service requested for retroactive eligibility (if applicable):

Providers who are contracted with Anthem Blue Cross and Blue Shield to serve Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging through an accountable care organization (ACO), participating medical group (PMG) or Independent Physician Association (IPA) are to follow guidelines and practices of the group. This includes but is not limited to authorization, covered benefits and services, and claims submittal. If you have questions, please contact your group administrator or your Anthem network representative.

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Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

Requested medication	Quantity	Dosing

General information applicable to all products:

Pulmonary antihypertensive PA requirements for all agents:

1. Member has a diagnosis of pulmonary arterial hypertension:
   ☐ Yes ☐ No
2. Member has a diagnosis of pulmonary hypertension associated with interstitial lung disease (only applicable to Tyvaso/Tyvaso DPI or Yutrepia DPI):
   ☐ Yes ☐ No
3. Member has a diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH) (only applicable to Adempas):
   ☐ Yes ☐ No
4. Requested agent has been prescribed by, or in consultation with, a pulmonologist or cardiologist:
   ☐ Yes ☐ No

Product-specific information:

If the request is for Adempas (riociguat):

1. For those of childbearing potential, a negative pregnancy test obtained in the past 30 days has been submitted:
   ☐ Yes ☐ No ☐ N/A
   Date of negative pregnancy test (include documentation):
   _____
2. Member is currently receiving one of the following: nitrate therapy, PDE-5 inhibitor, nonspecific PDE inhibitor (dipyridamole, theophylline, aminophylline,), vericiguat
   ☐ Yes ☐ No
3. Member is enrolled in the riociguat REMS program if meeting eligibility requirement:
   ☐ Yes ☐ No ☐ N/A
4. Dose requested is 7.5 mg per day or less:
   ☐ Yes ☐ No
   If no, please explain:
   _____
   _____

_____
_____

If the request is for Adcirca (tadalafil):

1. Member is currently receiving one of the following: nitrate therapy, PDE5 inhibitor (other than the one being requested), riociguat
   ☐ Yes ☐ No
2. Dose requested is 40 mg per day or less:
   ☐ Yes ☐ No
   Note: Alyq requires trial and failure of generic tadalafil or medical justification for use.

If the request is for Letairis (ambrisentan):

1. For those of childbearing potential, a negative pregnancy test obtained in the past 30 days has been submitted:
   ☐ Yes ☐ No ☐ N/A
   Date of negative pregnancy test (include documentation): _____
2. Member is currently receiving cyclosporine therapy (requires dose reduction):
   ☐ Yes ☐ No
   Note: dose of Letairis (ambrisentan) must be adjusted to max 5 mg/day
3. Member has had a previous trial and failure of Tracleer (bosentan):
   ☐ Yes ☐ No
   If no, please explain:
   _____
4. Dose requested is 10 mg per day or less: ☐ Yes ☐ No

If the request is for Liqrev (sildenafil) oral suspension:

1. Member is 18 years of age or older:
   ☐ Yes ☐ No
2. Member is unable to swallow tablet formulation:
   ☐ Yes ☐ No
3. Member is currently receiving one of the following: nitrate therapy, riociguat, atazanavir, darunavir, fosamprenavir, indinavir, lopinavir/ritonavir, nelfinavir, ritonavir, saquinavir, tipranavir, PDE-5 inhibitor (other than the one being requested):
   ☐ Yes ☐ No
4. Dose requested is 60 mg per day or less:
   ☐ Yes ☐ No
5. Member has had a previous trial and failure of sildenafil suspension:

☐ Yes ☐ No
If no, please explain:
_____

If the request is for Opsumit (macitentan):

1. For those of childbearing potential, a negative pregnancy test obtained in the past 30 days has been submitted:
   ☐ Yes ☐ No ☐ N/A
   Date of negative pregnancy test (include documentation): _____
2. Member has had a previous trial and failure of Tracleer (bosentan):
   ☐ Yes ☐ No
   If no, please explain:
   _____
3. Dose requested is 10 mg per day or less:
   ☐ Yes ☐ No

If the request is for Opsynvi (macitentan/tadalafil):

1. For those of childbearing potential, a negative pregnancy test obtained in the past 30 days has been submitted:
   ☐ Yes ☐ No ☐ N/A
   Date of negative pregnancy test (include documentation):
2. Member has had a previous trial and failure of separate components (macitentan and tadalafil):
   ☐Yes ☐ No
   If no, please explain:
   _____
3. Member is currently receiving one of the following: nitrate therapy, PDE-5 inhibitor (other than the one being requested), riociguat:
   ☐ Yes ☐ No
4. Dose requested is 10 mg/40 mg per day or less:
   ☐ Yes ☐ No

If the request is for Orenitram (treprostinil):

1. Does the member have severe hepatic impairment (Child-Pugh class C)?
   ☐ Yes ☐ No
   Note: Members with Child-Pugh class C hepatic impairment will be denied; Orenitram titration packs will be limited to one pack per 90 days.

If the request is for Revatio (sildenafil) tablets or injection:

1. Member is currently receiving one of the following: nitrate therapy, riociguat, atazanavir, darunavir, fosamprenavir, indinavir, lopinavir/ritonavir, nelfinavir, ritonavir, saquinavir, tipranavir, PDE-5 inhibitor (other than the one being requested):
   ☐ Yes ☐ No
2. Dose requested is 60 mg per day or less:
   ☐ Yes ☐ No

If the request is for Revatio (sildenafil) oral suspension:

1. Member is under 12 years of age:
   ☐ Yes ☐ No
2. Member is unable to swallow tablet formulation:
   ☐ Yes ☐ No
3. Member is currently receiving one of the following: nitrate therapy, riociguat, atazanavir, darunavir, fosamprenavir, indinavir, lopinavir/ritonavir, nelfinavir, ritonavir, saquinavir, tipranavir, PDE-5 inhibitor (other than the one being requested):
   ☐ Yes ☐ No
4. Dose requested is 60 mg per day or less:
   ☐ Yes ☐ No

If the request is for Tadliq (tadalafil) oral suspension:

1. Member is under 12 years of age:
   ☐ Yes ☐ No
2. Member is unable to swallow tablet formulation:
   ☐ Yes ☐ No
3. Member is currently receiving one of the following: nitrate therapy, PDE-5 inhibitor (other than the one being requested), riociguat:
   ☐ Yes ☐ No
4. Dose requested is 40 mg per day or less:
   ☐ Yes ☐ No
5. Select one of the following:
   - Member has had a previous trial and failure of sildenafil oral suspension:
     ☐ Yes ☐ No
     If no, please explain:
     _____
     _
   - Member requires Tadliq (tadalafil) as a less frequent dosing option (chart documentation must be submitted)

☐ Yes ☐ No

If the request is for Tracleer (bosentan):

Request is for:

☐ Tracleer tablet

☐ Tracleer dispersible tablet

☐ Bosentan tablet*

1. Member is enrolled in the bosentan REMS program (Note: All members must be enrolled in the bosentan REMS program):
   ☐ Yes ☐ No
2. For those of childbearing potential, a negative pregnancy test obtained in the past 30 days has been submitted:
   ☐ Yes ☐ No ☐ N/A
   Date of negative pregnancy test (include documentation):
3. Will the member be utilizing cyclosporine-A or glyburide therapy concurrently with bosentan?
   ☐ Yes ☐ No

Note: Members planning to use cyclosporine-A or glyburide concurrently with bosentan will be denied

4. Member age: _____ weight: _____ lb/kg (circle one)
5. Does the requested dose exceed 250mg per day OR dose limits based on age/weight listed in criteria?
   ☐Yes ☐ No
   If yes, please explain:
   _____

If the request is for Uptravi (selexipag):

1. Member has had a previous trial and failure of Orenitram (treprostinil):
   ☐ Yes ☐ No
   If no, please explain: _____
2. Will the member be utilizing a CYP2C8 inhibitor (such as gemfibrozil) concurrently with selexipag?
   ☐Yes ☐ No
   Note: Members planning to use CYP2C8 inhibitors concurrently with selexipag will be denied.

If the request is for Winrevair (sotarcept-csrk):

1. Member is 18 years of age or older:
   ☐ Yes ☐ No

2. Member has had a previous trial and failure of at least 60 days of therapy with any agent from two of the following subcategories: endothelin receptor antagonists, phosphodiesterase 5-inhibitors, prostacyclin receptor modulators, or soluble guanylate cyclase inhibitor:
   ☐ Yes ☐ No

If yes, please list each agent and dates of trial (start and stop dates, if therapy is ongoing indicate as such):

- Endothelin receptor antagonist:
  - Medication name: _____
  - Dates of trial: _____
- Phosphodiesterase 5-inhibitor:
  - Medication name: _____
  - Dates of trial: _____
- Prostacyclin receptor modulator:
  - Medication name: _____
  - Dates of trial: _____
- Soluble guanylate cyclase inhibitor:
  - Medication name: _____
  - Dates of trial: _____

If no, please explain: _____

3. Member's actual body weight: _____ lb/kg (circle one)
   Does the requested dose exceed 0.7 mg/kg every three weeks?
   ☐ Yes ☐ No
   If yes, please explain:
   _____
   _____
4. Prescriber attests to all of the following:
   a. Prescriber has obtained baseline hemoglobin and platelet count prior to initiating therapy:
      ☐ Yes ☐ No
   b. Baseline platelet count is 50,000/mm3 (50 x 106/L) or greater:
      ☐ Yes ☐ No
   c. Prescriber will continue to monitor hemoglobin and platelet count and adjust dosing per the prescribing information:
      ☐ Yes ☐ No

If the request is for Yutrepia (treprostinil) DPI:

1. Member has had a previous trial and failure of Tyvaso (treprostinil) DPI:
   ☐Yes ☐ No
   If no, please explain:
   _____

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