Jefferson Health Plans

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Endothelin Receptor Antagonists - Medicare

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

Jefferson Health 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 this request for reauthorization?

☐ Yes ☐ No

Q2. Is documentation provided indicating patient has improvement in condition?

☐ Yes ☐ No

Q3. Is the prescriber a cardiologist, pulmonologist, or Practitioner at a Pulmonary Hypertension Association-accredited center?

☐ Yes ☐ No

Q4. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q5. Is the patient female?

☐ Yes ☐ No

Q6. Is the patient pregnant?

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Patient Name:	**Prescriber Name:**

☐ Yes ☐ No

Q7. Is the patient able to get pregnant?

☐ Yes ☐ No

Q8. Will the patient use reliable forms of contraception?

☐ Yes ☐ No

Q9. Will the patient have pregnancy tests before therapy initiated and monthly during therapy?

☐ Yes ☐ No

Q10. Does the patient have one of the following contraindications: A) Idiopathic pulmonary fibrosis if being treated with ambrisentan, OR B) Using glyburide and/or cyclosporine A if being treated with bosentan?

☐ Yes ☐ No

Q11. Does the patient have the diagnosis of World Health Organization (WHO) Group 1 pulmonary arterial hypertension (PAH)?

☐ Yes ☐ No

Q12. Has the diagnosis of PAH been confirmed by a complete right heart catheterization (RHC), RHC results must be provided? PAH defined as: A. A mean pulmonary artery pressure (mPAP) greater than 20 mmHg; B. A pulmonary capillary wedge Pressure/left ventricular end-diastolic pressure (PCWP/LVEDP) or left atrial pressure of less than or equal to 15 mmHg; C. A pulmonary vascular resistance (PVR) of greater than 3 Wood units.

☐ Yes ☐ No

Q13. Will the patient's hemoglobin level be monitored?

☐ Yes ☐ No

Q14. Additional Information:

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Patient Name:	**Prescriber Name:**

Q15. Requested Duration:

☐ 12 months ☐ Other:

_____ _____

Prescriber Signature Date