

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.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	<b>Specialty/facility name (if applicable):</b>	

**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.**

<p>Q1. Is the prescriber a cardiologist or pulmonologist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q2. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q3. Is the patient a female?  [If No, skip to 8]</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q4. Is the patient pregnant?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. Is the patient able to get pregnant?  [If No, skip to 8]</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Will the patient use reliable forms of contraception?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Will the patient have pregnancy tests before therapy initiated and monthly during therapy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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<b>Patient Name:</b>	<b>Prescriber Name:</b>
<p>Q8. Does the patient have a contraindication such as idiopathic pulmonary fibrosis?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>	
<p>Q9. Does the patient have a diagnosis of World Health Organization (WHO) Group 1 pulmonary arterial hypertension (PAH)?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>	
<p>Q10. Has the diagnosis of pulmonary arterial hypertension (PAH) been confirmed by a complete right heart catheterization (RHC)? If Yes, please attach documentation.</p> <p>PAH is defined as:            A) A mean pulmonary arterial pressure (mPAP) greater than 20 mmHg            B) A pulmonary capillary wedge pressure/ left ventricular end-diastolic pressure (PCWP/LVEDP) less than or equal to 15 mmHg            C) A pulmonary vascular resistance (PVR) greater than 3 Wood units</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>	
<p>Q11. Will the patient's hemoglobin and hematocrit levels be monitored periodically (baseline, at 1 month, and periodically thereafter)?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>	
<p>Q12. Additional Information:</p>	
<p>Q13. Requested Duration:</p> <p><input type="checkbox"/> 12 Months</p>	

Prescriber Signature

Date

2022 Medicare Prior Authorization Request