

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 Uptravi being prescribed by or in consultation with 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. Does the patient have a diagnosis of World Health Organization (WHO) group 1 pulmonary arterial hypertension (PAH)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>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 / left ventricular end-diastolic pressure (PCWP /LVEDP) less than or equal to 15 mmHg ; III. A pulmonary vascular resistance (PVR) greater than 3 Wood units</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>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)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Has patient tried two therapies for PAH (or is currently receiving them) from two of the following categories (either alone or in combination): I. Endothelin Receptor Antagonists (bosentan, ambrisentan, macitentan); II.</p>

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<b>Patient Name:</b>	<b>Prescriber Name:</b>
Phosphodiesterase-5 inhibitors (sildenafil, tadalafil); III. Guanylate Cyclase stimulators (riociguat)	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Is there a treatment plan?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Will Uptravi be used along with a strong CYP2C8 inhibitor (eg gemfibrozil)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Does the patient have hepatic impairment (Child Pugh class B or greater)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. Additional Information:	
Q11. Duration:	
<input type="checkbox"/> 12 months	

\_\_\_\_\_  
 Prescriber Signature

\_\_\_\_\_  
 Date

2022 Medicare Prior Authorization Request