PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Uptravi - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Uptravi - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Uptravi (selexipag)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

[If yes, skip to question 10.]

2. Does the patient have a definitive diagnosis of pulmonary arterial hypertension? Y N

	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
3.	Was the diagnosis of pulmonary arterial hypertension confirmed by a cardiologist or pulmonologist by right heart catheterization?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
4.	Does the patient have World Health Organization (WHO) Functional Class II or Class III symptoms?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
5.	Has the pulmonary arterial hypertension progressed despite surgical treatment and/or maximal medical treatment?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
6.	Has the patient had treatment failure with oral calcium channel blockers?	Y N
	NOTE: Patients who have substantial reductions in pulmonary arterial pressure from short acting vasodilators at the time of catheterization may require high doses (e.g., nifedipine 240 milligrams per day (mg/day) or amlodipine 20 mg/day) \ NOTE: Submission of medical records is required.	
	[If yes, skip to question 8.]	
7.	Is the patient unable to take oral calcium channel blockers, or is their use inappropriate in this patient?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
8.	Has the patient had a documented trial and inadequate response to generic sildenafil or tadalafil?	Y N
	NOTE: Submission of medical records is required.	
	[If yes, skip to question 11.]	
9.	Does the patient have a documented contraindication to generic sildenafil or tadalafil?	Y N
	NOTE: Submission of medical records is required.	
	[If yes, skip to question 11.]	
	[If no, no further questions.]	
10.	Is there clinical documentation showing the patient has experienced improved exercise capacity or a delay in symptom worsening?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	

11. Will the requested drug be used in combination with one or more drugs with the same pharmacology when the patient has not adequately responded to monotherapy?	Y N
NOTE: Submission of medical records is required.	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date