



Flolan, Veletri and Epoprostenol

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4.

Patient's Name: _____ Date: _____
Patient's ID: _____ Patient's Date of Birth: _____
Physician's Name: _____
Specialty: _____ NPI#: _____
Physician Office Telephone: _____ Physician Office Fax: _____

Referring Provider Info: Same as Requesting Provider

Name: _____ NPI#: _____
Fax: _____ Phone: _____

Rendering Provider Info: Same as Referring Provider Same as Requesting Provider

Name: _____ NPI#: _____
Fax: _____ Phone: _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____ kg

Patient Height: _____ cm

Please indicate the place of service for the requested drug:

- Ambulatory Surgical Home Off Campus Outpatient Hospital
 On Campus Outpatient Hospital Office

Drug Information:

Strength/Measure _____ Units ml Gm mg ea Un

Directions(sig) _____ Route of administration _____

Dosing frequency _____

Send completed form to: Priority Partners Fax: 1-866-212-4756

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Flolan, Veletri and Epoprostenol SGM 1642-A – 12/2022.

Priority Partners • 7231 Parkway Drive Suite 100 • Hanover, MD 21076

Phone: 888-819-1043 • Fax: 1-866-212-4756 • www.jhhc.com

Criteria Questions:

1. What drug is being prescribed? Flolan Veletri epoprostenol Other _____
2. What is the diagnosis?
 Pulmonary arterial hypertension (PAH)
 Other, please specify _____
3. What is the ICD-10 code? _____
4. Is the requested medication prescribed by or in consultation with a pulmonologist or cardiologist? Yes No
5. Is the patient currently receiving treatment with the requested product? Yes No *If No, skip to #8*
6. Is the patient currently receiving the requested product through a paid pharmacy or medical benefit?
 Yes No Unknown *If No or Unknown, skip to #8*
7. Is the patient experiencing benefit from therapy as evidenced by disease stability or disease improvement?
 Yes No *No further questions*
8. What is the World Health Organization (WHO) classification of pulmonary hypertension?
 WHO Group 1 (Pulmonary arterial hypertension)
 WHO Group 2 (Pulmonary hypertension owing to left heart disease)
 WHO Group 3 (Pulmonary hypertension owing to lung disease and/or hypoxia)
 WHO Group 4 (Chronic thromboembolic pulmonary hypertension)
 WHO Group 5 (Pulmonary hypertension with unclear multifactorial mechanisms)
9. Has the diagnosis been confirmed by right heart catheterization? Yes No *If No, skip to #13*
10. What is the pretreatment mean pulmonary arterial pressure (mPAP) at rest? _____ mmHg
11. What is the pretreatment pulmonary capillary wedge pressure (PCWP)? _____ mmHg
12. What is the pretreatment pulmonary vascular resistance (PVR)? _____ Wood units *No further questions*
13. Is the patient an infant less than one year of age? Yes No
14. Has Doppler echocardiogram been performed to confirm the diagnosis? Yes No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X _____

Prescriber or Authorized Signature

Date (mm/dd/yy)

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