TRICARE Prior Authorization Request Form for
sildenafil 10 mg/mL oral suspension **(Liqrev)**

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100, Hanover, MD 21076

Fax Completed Form and Applicable Progress Notes to:
(410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Please note Liqrev will be completely excluded from the TRICARE pharmacy benefit starting on 2/28/2024, regardless of how long the PA is approved.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Provider acknowledges that Liqrev will be completely excluded from the Tricare Pharmacy Benefit starting on February 28th, 2024, regardless of how long the prior authorization is approved.	☐ Acknowledged Proceed to question **2**	
2. Provider acknowledges that generic sildenafil 10 mg/mL oral suspension (generic Revatio) is available without prior authorization.	☐ Acknowledged Proceed to question **3**	
3. What is the diagnosis?	☐ WHO group 1 pulmonary arterial hypertension (PAH) **Proceed to question 4**	☐ Other **STOP** **Coverage not approved**
4. Is the requested medication prescribed by a cardiologist or pulmonologist?	☐ Yes **Proceed to question 5**	☐ No **STOP** **Coverage not approved**
5. Has the patient had a right heart catheterization?	☐ Yes **Proceed to question 6**	☐ No **STOP** **Coverage not approved**

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6. Is documentation being provided to confirm that the patient had right heart catheterization that results confirm diagnosis of WHO Group 1 pulmonary arterial hypertension (PAH)? **PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Documentation may include, but is not limited to, chart notes and catheterization laboratory reports.**	☐ Yes **Proceed to question 7**	☐ No **STOP** **Coverage not approved**
7. Is the patient receiving other phosphodiesterase inhibitors (PDE-5 inhibitors), nitrates, or riociguat concomitantly?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 8**
8. Does the patient require a liquid formulation due to swallowing difficulty?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[15 Nov 2023]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: