Prior Authorization Request Form for
selexipag (**Uptravi**), treprostinil oral (**Orenitram ER**)

JOHNS HOPKINS MEDICINE
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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.

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. Does the patient have a documented diagnosis of WHO group 1 PAH?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication being prescribed by or in consultation with a cardiologist or a pulmonologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Has the patient had a right heart catheterization?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is documentation being provided to confirm that the patient has had a right heart catheterization? 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 **5**	☐ No **STOP** **Coverage not approved**
5. Did the results of the right heart catheterization confirm the diagnosis of WHO Group 1 PAH?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Has the patient tried one oral therapy for PAH from one of the three following different categories (either alone or in combination), each trial for greater than or equal to 60 days:	☐ one PDE-5 inhibitor (tadalafil or sildenafil) - **Sign and date below** ☐ one ERA (Letairis, Opsumit, or Tracleer) - **Sign and date below** ☐ Adempas - **Sign and date below** ☐ None - Proceed to question **7**	

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7. Has the patient tried one prostacyclin therapy (oral, IV, or nebulized)?	☐ 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

[23 October 2019]

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