

TRICARE Prior Authorization Request Form for
Sotatercept-csrk (**Winrevair**)



JOHNS HOPKINS
HEALTH PLANS

7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

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

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

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

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

Prior authorization does not expire.

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. Is the patient greater than or equal to 18 years of age?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Is the prescription written by or in consultation with a cardiologist or pulmonologist?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Does the patient have confirmed diagnosis of World Health Organization (WHO) Group 1 pulmonary arterial hypertension (PAH)?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
4. Does the patient have confirmed diagnosis of pulmonary arterial hypertension in WHO functional class II or III?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
5. Has the patient had right heart catheterization?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No STOP Coverage not approved
6. Has documentation been submitted to confirm the patient has had right heart catheterization? NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved

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<p>7. Has documentation been submitted to confirm that the patient has a diagnosis of (WHO) Group 1 pulmonary arterial hypertension (PAH)?</p> <p>NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.</p>	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> No STOP Coverage not approved
<p>8. Has documentation been submitted to confirm the patient is on stable background therapy for PAH (such as, monotherapy, double therapy, triple therapy)?</p> <p>NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.</p>	<input type="checkbox"/> Yes Proceed to question 9	<input type="checkbox"/> No STOP Coverage not approved
<p>9. Has documentation been submitted to confirm the patient has been on stable doses of diuretics for more than 90 days? (A stable dose of diuretic is defined as no addition of a new diuretic and no switching of an oral diuretic to parenteral administration. Dose adjustments for oral diuretics are acceptable).</p> <p>NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.</p>	<input type="checkbox"/> Yes proceed to question 10	<input type="checkbox"/> No STOP Coverage not approved
<p>10. What is the patient's gender?</p>	<input type="checkbox"/> Female Proceed to question 11	<input type="checkbox"/> Male Sign and date below
<p>11. Is the patient pregnant?</p>	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No proceed to question 12
<p>12. Is the patient of childbearing potential?</p>	<input type="checkbox"/> Yes proceed to question 13	<input type="checkbox"/> No Sign and date below
<p>13. Does the patient agree to use effective method of contraception during treatment and for at least 4 months after cessation of therapy?</p>	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> 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

[13 November 2024]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: