MHS PHARMACY BENEFIT
PULMONARY ANTIHYPERTENSIVES PRIOR AUTHORIZATION REQUEST FORM

MHS
550 N. Meridian St. Suite 101
Indianapolis, IN, 46204-1208
Phone: (877) 647-4848 Fax: (866) 399-0929

Today's Date
☐☐ / ☐☐ / ☐☐☐☐

Note: This form must be completed by the prescribing provider.
****All sections must be completed or the request will be returned****

Patient's Medicaid # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Prescriber's Signature
Return Fax # ☐☐☐ - ☐☐☐ - ☐☐☐☐	Return Phone # ☐☐☐ - ☐☐☐ - ☐☐☐☐
Check box if requesting retroactive PA ☐	Date(s) of service requested for retroactive eligibility (if applicable):

Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

Requested Medication	Strength	Quantity	Dosage Regimen

General information applicable to all products:

Pulmonary Antihypertensive PA Requirements:

1. Member has a diagnosis of pulmonary hypertension ☐ Yes ☐ No
2. Member has a diagnosis of pulmonary hypertension associated with interstitial lung disease (only applicable to Tyvaso/Tyvaso DPI) ☐ Yes ☐ No

Note: A diagnosis of pulmonary hypertension is required for plan approval, excluding Adempas.

3. Requested agent has been prescribed by, or in consultation with, a pulmonologist or cardiologist ☐ Yes ☐ No

Product-specific information:

If the request is for Adempas (riociguat):

1. Please select member's diagnosis
   - ☐ Pulmonary hypertension
   - ☐ Chronic thromboembolic pulmonary hypertension (CTEPH)

2. Member has had a negative pregnancy test in the past 30 days
   ☐ Yes ☐ No ☐ Not applicable to member
   Date of negative pregnancy test (include documentation): _____

3. Member is currently receiving one of the following: nitrate therapy, PDE5 inhibitor, nonspecific PDE inhibitor (dipyridamole; theophylline; aminophylline), vericiguat ☐ Yes ☐ No

4. Member is enrolled in the riociguat REMS program if meeting eligibility requirement
   ☐ Yes ☐ No ☐ Not applicable to member

5. Requested dose is 7.5mg per day or less ☐ Yes ☐ No

   If no, please explain:_____

If the request is for Adcirca (tadalafil):

1. Member is currently receiving one of the following: nitrate therapy, PDE-5 inhibitor (other than the one being requested), riociguat ☐ Yes ☐ No

2. Dose requested is 40 mg per day or less ☐ Yes ☐ No

Note: 'Alyq' requires trial and failure of generic tadalafil or medical justification for use.

If the request is for Letairis (ambrisentan):

1. Member is enrolled in the ambrisentan or PS-ambrisentan REMS program if meeting eligibility requirement
   ☐ Yes ☐ No ☐ Not applicable to member

2. Member has had a negative pregnancy test in the past 30 days
   ☐ Yes ☐ No ☐ Not applicable to member
   Date of negative pregnancy test (include documentation): _____

3. Member is currently receiving cyclosporine therapy (requires dose reduction) ☐ Yes ☐ No
   Note: Dose of Letairis (ambrisentan) must be adjusted to max: 5 mg/day.

4. Member has had a previous trial and failure of Tracleer (bosentan) ☐ Yes ☐ No

   If no, please explain_____

5. Dose requested is 10 mg per day or less ☐ Yes ☐ No

If the request is for Opsumit (macitentan):

1. Member is enrolled in the macitentan REMS program if meeting eligibility requirement
   ☐ Yes ☐ No ☐ Not applicable to member

2. Member has had a negative pregnancy test in the past 30 days
   ☐ Yes ☐ No ☐ Not applicable to member
   Date of negative pregnancy test (include documentation): _____

3. Member has had a previous trial and failure of Tracleer (bosentan) ☐ Yes ☐ No
   If no, please explain_____

4. Dose requested is 10 mg per day or less ☐ Yes ☐ No

If the request is for Orenitram (treprostinil):

1. Does the member have severe hepatic impairment (Child-Pugh class C)? ☐ Yes ☐ No
   Note: Members with Child-Pugh class C hepatic impairment will be denied.

If the request is for Revatio (sildenafil) tablets or injection:

1. Member is currently receiving one of the following: nitrate therapy, riociguat, atazanavir, darunavir, fosamprenavir, indinavir, lopinavir/ritonavir, nelfinavir, ritonavir, saquinavir, tipranavir, PDE-5 inhibitor (other than the one being requested) ☐ Yes ☐ No

2. Dose requested is 60 mg per day or less ☐ Yes ☐ No

If the request is for Revatio (sildenafil) oral suspension:

1. Member is under 18 years of age ☐ Yes ☐ No

2. Member is unable to swallow tablet formulation ☐ Yes ☐ No

3. Member is currently receiving one of the following: nitrate therapy, riociguat, atazanavir, darunavir, fosamprenavir, indinavir, lopinavir/ritonavir, nelfinavir, ritonavir, saquinavir, tipranavir, PDE-5 inhibitor (other than the one being requested) ☐ Yes ☐ No

4. Dose requested is 60 mg per day or less ☐ Yes ☐ No

   Note: Revatio Suspension is brand preferred. Authorization for generic sildenafil oral suspension is contingent upon medical necessity for use instead of the branded agent.

If the request is for Tadliq (tadalafil) oral suspension:

1. Member is under 18 years of age ☐ Yes ☐ No
2. Member is unable to swallow tablet formulation ☐ Yes ☐ No
3. Member is currently receiving one of the following: nitrate therapy, PDE-5 inhibitor (other than the one being requested), riociguat ☐ Yes ☐ No
4. Dose requested is 40 mg per day or less ☐ Yes ☐ No
5. Member has had a previous trial and failure of Revatio (sildenafil) oral suspension ☐ Yes ☐ No

   If no, please explain_____

If the request is for Uptravi (selexipag):

1. Member has had a previous trial and failure of Orenitram (treprostinil) ☐ Yes ☐ No

   If no, please explain_____

2. Will the member be utilizing a CYP2C8 inhibitor (e.g., gemfibrozil) concurrently with selexipag? ☐ Yes ☐ No

   Note: members planning to use CYP2C8 inhibitors concurrently with selexipag will be denied.

If the request is for Tracleer (bosentan):

Request is for:
☐ Tracleer tablet
☐ Tracleer dispersible tablet
☐ Bosentan tablet*

1. Member is enrolled in the bosentan REMS program (***Note**: ALL members **must** be enrolled in the bosentan REMS program.)* ☐ Yes ☐ No
2. Member has had a negative pregnancy test in the past 30 days
   ☐ Yes ☐ No ☐ Not applicable to member
   Date of negative pregnancy test (include documentation): _____
3. Will the member be utilizing cyclosporine-A or glyburide therapy concurrently with bosentan?
   ☐ Yes ☐ No
   Note: Members planning to use cyclosporine-A or glyburide concurrently with bosentan will be denied.
4. Member age: _____ weight: _____ LB/KG (circle one)
5. Does the requested dose exceed 250mg per day OR dose limits based on age/weight listed in criteria? ☐ Yes ☐ No

   If yes, please explain: _____