Pulmonary Hypertension (Oral Medications) Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
Phone: 1-855-240-0535
FAX: 1-877-269-9916

For Medicare Advantage Part B:
Phone: 1-866-503-0857
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one)*: ☐ **Cardiologist** ☐ **Pulmonologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *(Patient selected choice)*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: ☐ Adcirca (tadalafil) ☐ Adempas (riociguat) ☐ Alyq (tadalafil) ☐ ambrisentan ☐ bosentan ☐ Letairis (ambrisentan) ☐ Opsumit (macitentan) ☐ sildenafil ☐ Orenitram (treprostinil extended-release tablets) ☐ Revatio (sildenafil) ☐ tadalafil ☐ Tracleer (bosentan) ☐ Uptravi (selexipag)

Dose: _____ **Frequency:** _____

For Revatio (sildenafil) only, please select administration: ☐ suspension ☐ tablet

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required):

Please indicate the severity of the patient's symptoms using the World Health Organization (WHO) functional classification system:
Select one: ☐ I ☐ II ☐ III ☐ IV

☐ Yes ☐ No Was the mean pulmonary artery pressure documented by right heart catheterization or echocardiography?
→ Please indicate test and results: ☐ echocardiography ☐ right heart catheterization
At rest: _____ mmHg With exertion: _____ mmHg

☐ Yes ☐ No Does the patient have a diagnosis of Pulmonary hypertension?

If yes, please identify the type of Pulmonary hypertension:

☐ Chronic thromboembolic pulmonary hypertension (CTEPH) ☐ Hereditary PAH due to activin receptor-like kinase type 1 (ALK1),endoglin, mothers against decapentaplegic 9 (SMAD9), caveolin-1 (CAV1), or potassium channel subfamily K member-3 (KCNK3) ☐ Hereditary PAH due to bone morphogenetic protein receptor type 2 (BMPR2) ☐ Hereditary PAH due to unknown causes ☐ Idiopathic PAH (formerly primary pulmonary hypertension) ☐ PAH due to diseases that localize to small pulmonary arterioles, including drug and toxin-induced (e.g., anorectic agents (diet drugs)) ☐ PAH associated with congenital heart disease ☐ PAH associated with connective tissue diseases ☐ PAH associated with HIV infection ☐ PAH associated with portal hypertension ☐ PAH associated with schistosomiasis ☐ Persistent pulmonary hypertension of the newborn (PPHN) (such as associated with congenital diaphragmatic hernia) ☐ Pulmonary hypertension associated with pulmonary veno-occlusive disease (PVOD) or pulmonary capillary hemangiomatosis (PCH) ☐ Sarcoidosis associated with pulmonary hypertension ☐ Other:_____

Continued on next page

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G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

☐ Yes ☐ No ☐ **N/A** Has the patient undergone an acute vasoreactivity test prior to initiation of therapy?
- ☐ Yes ☐ No Is an acute vasoreactivity test contraindicated due to right heart failure, low systemic blood pressure, low cardiac index, or presence of severe (functional class IV) symptoms?
  - Please select: ☐ low cardiac index ☐ low systemic blood pressure ☐ right heart failure ☐ severe functional class IV symptoms
- ☐ Yes ☐ No Did the patient have a **positive** acute vasoreactivity test result (defined as a decrease in mPAP (mean pulmonary artery pressure) at least 10 mmHg to an absolute level of less than 40 mgHg without a decrease in cardiac output)?
  - ☐ Yes ☐ No Does the patient have a documented trial and failure of a calcium channel blocker (dihydropyridine or diltiazem)?
    - ☐ Yes ☐ No Does the patient have a contraindication to a calcium channel blocker (e.g., right heart failure, hemodynamic instability)?

For Initiation Requests:

Adcirca (tadalafil), Revatio (sildenafil) tablets:

☐ Yes ☐ No Is the patient concurrently on organic nitrates (e.g., isosorbide mononitrate, isosorbide dinitrate, nitroglycerin)?
☐ Yes ☐ No Is the patient concurrently on guanylate cyclase (GC) stimulators (e.g., Adempas (riociguat))?
☐ Yes ☐ No Has the patient had an adequate trial of sildenafil, Alyq (tadalafil) or tadalafil?
- ☐ Yes ☐ No Does the patient have a documented contraindication or intolerance or allergy to sildenafil, Alyq (tadalafil) or tadalafil?
  - Please select: ☐ sildenafil ☐ Alyq (tadalafil) ☐ tadalafil
  - Please select: ☐ allergy ☐ contraindication ☐ intolerance
- Please select: ☐ sildenafil ☐ Alyq (tadalafil) ☐ tadalafil
- Please indicate length of trial:
  - ☐ Less than 1 month
    - ☐ Yes ☐ No Does the patient have a documented contraindication or intolerance or allergy to sildenafil, Alyq (tadalafil) or tadalafil?
  - ☐ 1 month ☐ 2 months ☐ 3 months or greater

For tadalafil, Alyq (tadalafil), sildenafil or Revatio (sildenafil suspension) only:

☐ Yes ☐ No Is the patient concurrently on organic nitrates (e.g., isosorbide mononitrate, isosorbide dinitrate, nitroglycerin)?
☐ Yes ☐ No Is the patient concurrently on guanylate cyclase (GC) stimulators (e.g., Adempas (riociguat))?

Adempas (riociguat):

☐ Yes ☐ No Is the patient concurrently on organic nitrates (e.g., isosorbide mononitrate, isosorbide dinitrate, nitroglycerin)?
☐ Yes ☐ No Is the patient concurrently using PDE inhibitors (e.g., sildenafil, Adcirca (tadalafil), dipyridamole or theophylline)?
☐ Yes ☐ No Is the patient pregnant?

For pulmonary hypertension:

☐ Yes ☐ No Has the patient had an adequate trial of sildenafil, Alyq (tadalafil) or tadalafil?
- ☐ Yes ☐ No Does the patient have a documented contraindication or intolerance or allergy to sildenafil, Alyq (tadalafil) or tadalafil?
  - Please select: ☐ sildenafil ☐ Alyq (tadalafil) ☐ tadalafil
  - Please select: ☐ allergy ☐ contraindication ☐ intolerance
- Please select: ☐ sildenafil ☐ Alyq (tadalafil) ☐ tadalafil
- Please indicate length of trial: ☐ Less than 1 month
  - ☐ Yes ☐ No Does the patient have a documented contraindication or intolerance or allergy to sildenafil, Alyq (tadalafil) or tadalafil?
  - ☐ 1 month ☐ 2 months ☐ 3 months or greater

☐ Yes ☐ No Has the patient had an adequate trial of ambrisentan, Letairis (ambrisentan), Opsumit (macitentan), or bosentan?
- ☐ Yes ☐ No Does the patient have a documented contraindication or intolerance or allergy to ambrisentan, Letairis (ambrisentan), Opsumit (macitentan), or bosentan?
  - Please select: ☐ ambrisentan ☐ Letairis (ambrisentan) ☐ Opsumit (macitentan) ☐ bosentan
  - Please select: ☐ allergy ☐ contraindication ☐ intolerance
- Please select: ☐ ambrisentan ☐ Letairis (ambrisentan) ☐ Opsumit (macitentan) ☐ bosentan
- Please indicate length of trial: ☐ Less than 1 month
  - ☐ Yes ☐ No Does the patient have a documented contraindication or intolerance or allergy to ambrisentan, Letairis(ambrisentan), Opsumit (macitentan), or bosentan?
  - ☐ 1 month ☐ 2 months ☐ 3 months or greater

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G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

For chronic thromboembolic pulmonary hypertension (CTEPH):

☐ Yes ☐ No Is the request for a patient for whom surgery is not an option or for use after surgical treatment?
→ Please select: ☐ surgery is not an option ☐ for use after surgical treatment

☐ Yes ☐ No Does the patient have a documented thromboembolic occlusion of the pulmonary vasculature?

For ambrisentan, Letairis (ambrisentan), Opsumit (macitentan), bosentan or Tracleer (bosentan):

☐ Yes ☐ No Is the patient pregnant?

Orenitram (treprostinil extended-release tablets) or Uptravi (selexipag):

☐ Yes ☐ No Does the patient have severe hepatic impairment (Child Pugh Class C)?

☐ Yes ☐ No Will the patient be converted from an infused, inhaled or oral vasodilator (e.g., epoprostenol, treprostinil, or iloprost)?
→ Please select: ☐ inhaled vasodilator ☐ infused vasodilator ☐ oral vasodilator

☐ Yes ☐ No Will the patient be on concurrent therapy with another vasodilator (e.g., epoprostenol, treprostinil, or iloprost)?
→ Please select: ☐ epoprostenol ☐ iloprost ☐ treprostinil

Tracleer (bosentan):

☐ Yes ☐ No Has the patient had an adequate trial of bosentan?
→ ☐ Yes ☐ No Does the patient have a documented contraindication or intolerance or allergy to bosentan?
→ Please select: ☐ allergy ☐ contraindication ☐ intolerance

→ Please indicate length of trial: ☐ Less than 1 month
→ ☐ Yes ☐ No Does the patient have a documented contraindication or intolerance or allergy to bosentan?
→ Please select: ☐ allergy ☐ contraindication ☐ intolerance

☐ 1 month ☐ 2 months ☐ 3 months or greater

For Continuation of Therapy Requests:

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of requested medication? (Sampling of requested medication does not guarantee coverage under the provisions of the pharmacy benefit.)

☐ Yes ☐ No Is there clinical documentation indicating disease stability or improvement?
→ Please select: ☐ disease stability ☐ disease improvement

For Adcirca (tadalafil), Alyq (tadalafil), tadalafil, Revatio (sildenafil) and sildenafil ONLY:

☐ Yes ☐ No Is the patient concurrently on organic nitrates (e.g., isosorbide mononitrate, isosorbide dinitrate, nitroglycerin)?

☐ Yes ☐ No Is the patient concurrently on guanylate cyclase (GC) stimulators (e.g., Adempas (riociguat))?

For Adempas (riociguat) with the diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH) ONLY:

☐ Yes ☐ No Is the request for a patient for whom surgery is not an option or for use after surgical treatment?
→ Please select: ☐ surgery is not an option ☐ for use after surgical treatment

☐ Yes ☐ No Is the patient concurrently on organic nitrates (e.g., isosorbide mononitrate, isosorbide dinitrate, nitroglycerin)?

☐ Yes ☐ No Is the patient concurrently using PDE inhibitors (e.g., sildenafil, Adcirca (tadalafil), dipyridamole or theophylline)?

☐ Yes ☐ No Is the patient pregnant?

For ambrisentan, Letairis (ambrisentan), Opsumit (macitentan), bosentan or Tracleer (bosentan) ONLY:

☐ Yes ☐ No Is the patient pregnant?

For Orenitram (treprostinil extended-release tablets) or Uptravi (selexipag) ONLY:

☐ Yes ☐ No Does the patient have severe hepatic impairment (Child Pugh Class C)?

☐ Yes ☐ No Will the patient be on concurrent therapy with another vasodilator (e.g., epoprostenol, treprostinil, or iloprost)?
→ Please select: ☐ epoprostenol ☐ iloprost ☐ treprostinil

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.