maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Winrevair

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	Is the request an INITIAL or CONTINUATION of therapy? [] Initial (If checked, go to 7) [] Continuation (If checked, go to 2)		
2	Has the patient been receiving medication samples of Winrevair? [If yes, skip to question 7.]	Yes	No
3	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the	Yes	No

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	requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]		
4	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
5	Is the requested medication prescribed by or in consultation with a cardiologist or pulmonologist? [If no, no further questions.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	What is the indication or diagnosis? [] Pulmonary Arterial Hypertension (PAH) WHO Group 1 (If checked, go to 8) [] Other (If checked, no further questions)		
8	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
9	Has the patient had a right heart catheterization documenting a minimum pulmonary vascular resistance (PVR) of greater than or equal to 5 Wood units (WU) and a pulmonary capillary wedge pressure (PCWP) or left ventricular end-diastolic pressure of less than or equal to 15 mmHg? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
10	Is the patient in functional Class II or III? [If no, no further questions.]	Yes	No
11	Has documentation been submitted to confirm the patient has experienced intolerance, contraindication to, failed treatment for at least 3 months with a calcium channel blocker? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
12	Is the patient currently receiving at least TWO other PAH therapies from at least two different categories, each for more than 90 days: phosphodiesterase type 5 inhibitors (PDE5i), endothelin receptor antagonists (ERAs), soluble guanylate cyclase stimulator (sGCs), and prostacyclins? [If yes, skip to question 14.]	Yes	No
13	Is the patient currently receiving at least ONE other PAH therapy for more than 90 days and is intolerant to combination therapy with a phosphodiesterase type 5	Yes	No

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	inhibitors (PDE5i), endothelin receptor antagonists (ERAs), soluble guanylate cyclase stimulator (sGCs), or prostacyclin? [If no, no further questions.]		
14	Does the provider attest that the requested medication will be used as add-on therapy to be used in combination with other pulmonary arterial hypertension agents? [If no, no further questions.]	Yes	No
15	Does the patient have a baseline platelet count greater than or equal to 50,000/mm^3? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
16	Does the patient have a baseline hemoglobin (Hgb) level within normal limits? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
17	Does the provider attest that complete blood count (CBC) bloodwork will be obtained before each dose for the first 5 doses? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
18	Has documentation been submitted to confirm baseline 6-minute walk test? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
19	Is the requested medication prescribed by or in consultation with a cardiologist or pulmonologist?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

If you have any questions, call: 1-888-258-8250

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