

# Pulmonary Hypertension Agents Prior Authorization of Benefits Form

## Contains confidential patient information

## Complete form in its entirety and fax to the Prior Authorization of Benefits Center at 1-844-474-3341.

1	Dationt	information
т.	ratient	innormation

#### 2. Physician information

Patient name:	Prescribing physician:
Patient ID #:	Physician address:
Patient DOB:	Physician phone #:
Date of Rx:	Physician fax #:
Patient phone #:	Physician specialty:
Patient email address:	Physician DEA:
	Physician NPI #:
	Physician email address:

3. Medication	4. Strength	5. Directions	6. Quantity per 30 days
			Specify:
7. Diagnosis:			

**8.** Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Injectable agents			
🗆 Yes	□ No	Does the client have a diagnosis of pulmonary arterial hypertension (PAH) in the last 730 days?	
□ Yes	□ No	Has the diagnosis been confirmed by or does the client have a contraindication to right heart catheterization?	
🗆 Yes	🗆 No	Has the client tried other available PAH therapies in the last 180 days?	
Yes	□ No	Does the client have a contraindication to other available PAH therapies	
Oral/inhaled agents			
🗆 Yes	□ No	Does the client have a diagnosis of PAH in the last 730 days?	
□ Yes	□ No	Does the client have a diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH) in the last 730 days?	
□ Yes	□ No	Has the diagnosis been confirmed by or does the client have a contraindication to right heart catheterization?	
□ Yes	□ No	Has the diagnosis been confirmed by or does the client have a contraindication to pulmonary angiogram?	

Amerigroup members in the Medicaid Rural Service Area and the STAR Kids program are served by Amerigroup Insurance Company; all other Amerigroup members in Texas are served by Amerigroup Texas, Inc.

Non-preferred agents			
🗆 Yes	□ No	Patient has failed a 30-day treatment trial with at least one preferred agent(s) within the past 180 days.	
🗆 Yes	□ No	Patient has a documented allergy or contraindication to preferred agents in this class.	
🗆 Yes	□ No	Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.	
For the Texas Medicaid Preferred Drug List, please refer to the Texas Medicaid Vendor Drug Program website at			

For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at http://www.txvendordrug.com/formulary/formulary-search.asp.

### 9. Physician signature

Prescriber or authorized signature

Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.