UnitedHealthcare Community Plan

Pulmonary Arterial Hypertension Agents, Oral and Inhaled
Prior Authorization Request Form

Please complete this entire form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP:
Phone:	Date of Birth:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication □ New or □ Continuation of Therapy? If continuation, list start date: _____
Is this patient currently hospitalized? □ Yes □ No

Section B - Physician Information

First Name:		Last Name:		
Address:		City:	State:	ZIP:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax Attention to:				

Section C - Medical Information

Medication: **Strength:**

Directions for use: **Quantity:**

Diagnosis (Please be specific & provide as much information as possible)**:** **ICD-10 Code:**

Is this member pregnant? □ Yes □ No **If yes, what is this member's due date? _____**

Section D – Clinical Information

- Is there a clinical reason why the patient cannot use a preferred medication? □ Yes □ No
If yes, list reason: _____
- Does the patient have persistent/recurrent Chronic Thromboembolic Pulmonary Hypertension (CTEPH) after surgical treatment or inoperable CTEPH? □ Yes □ No

Requests for Adcirca or Revatio:
- Does the patient have a diagnosis of pulmonary arterial hypertension (PAH)? □ Yes □ No
If no, list diagnosis: _____

Requests for Adempas:
- Does the patient have any of the following: □ Yes □ No
□ PAH
□ CTEPH
□ Other, list: _____

Requests for Revatio Suspension:
- Does the patient have a diagnosis of Pulmonary Arterial Hypertension (PAH)? □ Yes □ No
- Is there a clinical reason why the patient cannot use sildenafil tablets? □ Yes □ No
If yes, list reason: _____

Section E – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for Failure or Discontinuation

Physician Signature: _____ Date: _____