Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Phosphodiesterase-5 Inhibitors

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the request for reauthorization? If YES, go to 2. If NO, go to 3.

☐ Yes ☐ No

Q2. Is there confirmation of positive clinical response or stabilization?

☐ Yes ☐ No

Q3. Is the drug being prescribed by or in consultation with a cardiologist, pulmonologist, practitioner at a Pulmonary Hypertension Association-Accredited center, or rheumatologist?

☐ Yes ☐ No

Q4. Will the patient take the drug in combination with either of the following: A) Organic nitrates, or B) guanylate cyclase (GC) stimulators (e.g., riociguat)?

☐ Yes ☐ No

Q5. Does the patient have confirmation of a diagnosis of World Health Organization (WHO) Group 1 pulmonary arterial hypertension (PAH)?

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☐ Yes ☐ No

Q6. Has the diagnosis of PAH been confirmed documented by lab results attached of a complete right heart catheterization (RHC) and are the RHC results provided? PAH defined as:

o A mean pulmonary artery pressure (mPAP) greater than 20 mmHg
o A pulmonary capillary wedge Pressure/ left ventricular end diastolic pressure (PCWPLVEDP) less than or equal to 15 mmHg
o A pulmonary vascular resistance (PVR) greater than 2 Wood units.

☐ Yes ☐ No

Q7. Does the patient have a diagnosis of Raynaud's phenomenon?

☐ Yes ☐ No

Q8. Has the patient had an inadequate response or intolerance to one calcium channel blocker?

☐ Yes ☐ No

Q9. Is the requested agent a formulary drug?

☐ Yes ☐ No

Q10. Does the patient have documentation of inadequate response, intolerance, or contraindication to formulary agents indicated for patient's diagnosis that would not be expected to occur with requested agent.

☐ Yes ☐ No

Q11. Additional Information:

_____ _____

Prescriber Signature Date

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