Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Ventavis

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 this request for reauthorization? If YES, go to 2. If NO, go to 3.

☐ Yes ☐ No

Q2. Is documentation provided indicating patient has improvement in condition?

☐ Yes ☐ No

Q3. Is the requested drug prescribed by or in consultation with a cardiologist, pulmonologist, or Practitioner at a Pulmonary Hypertension Association-accredited center?

☐ Yes ☐ No

Q4. Does the member have the diagnosis of World Health Organization (WHO) Group 1 pulmonary arterial hypertension (PAH)?

☐ Yes ☐ No

Q5. Has the diagnosis of PAH been confirmed by a complete right catheterization (RHC) (please attach RHC report)? PAH is defined as:

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Patient Name:	**Prescriber Name:**

I. A mean pulmonary arterial pressure (mPAP) greater than 20 mmHg

II. A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg

III. A pulmonary vascular resistance (PVR) greater than 2 Wood units

☐ Yes ☐ No

Q6. Does the patient have a NYHA/WHO functional class of III (marked limitation of physical activity from PAH. Patient is comfortable at rest, but less than ordinary physical activity causes undue dyspnea or fatigue, chest pain, or near syncope) or IV (inability to carry out any physical activity without symptoms. Patient has signs of right heart failure. Dyspnea and/or fatigue may be present at rest. Discomfort is increased by any physical activity and may result in syncope)?

☐ Yes ☐ No

Q7. Additional Information:

Prescriber Signature

Date

v2026

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