

Winrevair - Non-PDL
Phone: 215-991-4300
Fax back to: 866-240-3712

Health Partners 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.

Member Name:		Prescriber Name:	
HPP Member Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Member Primary Phone:	NPI:	PA PROMISe ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		
<i>HPP's maximum approval time is 12 months but may be less depending on the drug.</i>			

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 patient prescribed a dose and duration of therapy consistent with the FDA approved package labeling?

 Yes

 No

Q2. Is this a request for a renewal? If YES, go to question 3. If NO, go to question 4

 Yes

 No

Q3. Is there documentation of positive clinical response and/or tolerance to the requested medication?

 Yes

 No

Q4. Is the patient 18 years of age or older?

 Yes

 No

Q5. Is there documentation of a diagnosis of pulmonary arterial hypertension (PAH) WHO Group I confirmed by right heart catheterization with all of the following? a. Mean pulmonary arterial pressure (mPAP) > 20 mmHg; b. Pulmonary capillary wedge pressure (PCWP) = 15 mmHg; c. Pulmonary vascular resistance (PVR) = 3 Wood units

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Member Name:	Prescriber Name:
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q6. Is there documentation patient is Functional Class II, III, or IV at baseline prior to initiating therapy with Winrevair? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. Is the medication prescribed by or in consultation with a cardiologist or pulmonologist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. For patients newly starting therapy with Winrevair, ONE of the following: a. The patient is currently receiving at least two other PAH therapies from the following drug classes: Endothelin receptor antagonist (e.g., Letairis, Opsumit, Tracleer); Phosphodiesterase-5 inhibitor (e.g., Adcirca, Revatio); Soluble guanylate cyclase stimulator (e.g., Adempas); Prostacyclin analog (e.g., Flolan, Orenitram, Remodulin, Tyvaso, Veletri, Ventavis); Prostacyclin receptor agonist (e.g., Uptravi); b. The patient is currently receiving at least one other PAH therapy from the drug classes listed in 8.a. and the prescriber attests the member is unable to tolerate/not a candidate for combination therapy). <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Does the patient have any contraindications to Winrevair (sotatercept-csrk)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q10. Additional Information:	

 Prescriber Signature

 Date

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