



**MEDICAID / CHIP**  
**PHARMACY PRIOR AUTHORIZATION REQUEST FORM**

**Pulmonary Hypertension Agents - Oral & Inhaled**

Phone: 866-841-7659

Fax back to: 866-240-3712

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.**

Member Name:		Prescriber Name:	
Member ID Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Member Phone Number:	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>Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..</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. The request is for a Pulmonary Hypertension Agent that was previously approved. If YES, go to 14.

Yes

No

Q2. The member meets ONE of the following:

Is prescribed the drug for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication, excluding use to treat sexual or erectile dysfunction

For the treatment of pulmonary arterial hypertension (PAH), is prescribed a Pulmonary Hypertension Agent, Oral and Inhaled that is appropriate for the beneficiary's clinical status and current peer-reviewed medical literature

Q3. The member is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

Yes

No

Q4. If under 18 years of age, the member is prescribed the Pulmonary Hypertension Agent, Oral and Inhaled by or in consultation with a pediatric pulmonologist or pediatric cardiologist.

Yes

No

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Q5. If 18 years of age or older, ONE of the following:

- |   |  |
|---|--|
| <input type="checkbox"/> Is prescribed the Pulmonary Hypertension Agent, Oral and Inhaled by or in consultation with a practitioner at a Pulmonary Hypertension Association-accredited center | <input type="checkbox"/> If unable to access a Pulmonary Hypertension Association-accredited center, is prescribed the Pulmonary Hypertension Agent, Oral and Inhaled by or in consultation with an appropriate specialist (i.e., pulmonologist, cardiologist, or rheumatologist) skilled in treating pulmonary hypertension |
|---|--|

Q6. The member does not have a contraindication to the prescribed drug.

- Yes
  No

Q7. For a diagnosis of PAH (WHO Group 1), has chart documentation of right heart catheterization indicating ALL of the following hemodynamic values:

- A mean pulmonary arterial pressure (mPAP) greater than or equal to 25 mmHg
- A pulmonary capillary wedge pressure (PCWP), left atrial pressure, or left ventricular end-diastolic pressure less than or equal to 15 mmHg
- A pulmonary vascular resistance (PVR) greater than 3 Wood units

Q8. For a beneficiary with idiopathic or heritable PAH, one of the following:

- |  |  |
|--|--|
| <input type="checkbox"/> Has chart documentation of acute vasoreactivity testing | <input type="checkbox"/> Has a contraindication to vasoreactivity testing or is at increased risk of adverse events during acute vasoreactivity testing (e.g., presence of severe [functional class IV] symptoms, low systemic blood pressure, low cardiac index, or pulmonary veno-occlusive disease) |
|--|--|

Q9. For a member with idiopathic or heritable PAH that demonstrates acute vasoreactivity, has a documented history of therapeutic failure of or a contraindication or an intolerance to calcium channel blockers (i.e., amlodipine, nifedipine, or diltiazem).

- Yes
  No

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Q10. For a diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH), has chart documentation of right heart catheterization indicating BOTH of the following hemodynamic values:

- An mPAP greater than or equal to 25 mmHg
  A PVR greater than 3 Wood units

Q11. For a diagnosis of pulmonary hypertension associated with interstitial lung disease (PH-ILD; WHO Group 3), has chart documentation of right heart catheterization indicating all of the following hemodynamic values:

- An mPAP greater than or equal to 25 mmHg  
 A PCWP less than or equal to 15 mmHg  
 A PVR greater than 3 Wood units

Q12. Chart documentation of recent computed tomography imaging demonstrating interstitial lung disease.

- Yes
  No

Q13. For a non-preferred Pulmonary Hypertension Agent, Oral and Inhaled, ONE of the following:

- |  |  |
|--|--|
| <input type="checkbox"/> Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Pulmonary Hypertension Agents, Oral and Inhaled approved or medically accepted for the beneficiary's diagnosis or indication | <input type="checkbox"/> Has a current history (within the past 90 days) of being prescribed the same non-preferred Pulmonary Hypertension Agent, Oral and Inhaled (does not apply to non-preferred brands when the therapeutically equivalent generic is preferred or to non-preferred generics when the therapeutically equivalent brand is preferred). See the Preferred Drug List (PDL) for the list of preferred Pulmonary Hypertension Agents, Oral and Inhaled at:<br><a href="https://papdl.com/preferred-drug-list">https://papdl.com/preferred-drug-list</a> . |
|--|--|

Q14. The member continues to benefit from the requested agent based on the prescriber's assessment.

- Yes
  No



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Q15. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

Yes  No

Q16. If under 18 years of age, the member is prescribed the Pulmonary Hypertension Agent, Oral and Inhaled by or in consultation with a pediatric pulmonologist or pediatric cardiologist.

Yes  No

Q17. If 18 years of age or older, ONE of the following:

Is prescribed the Pulmonary Hypertension Agent, Oral and Inhaled by or in consultation with a practitioner at a Pulmonary Hypertension Association-accredited center

If unable to access a Pulmonary Hypertension Association-accredited center, is prescribed the Pulmonary Hypertension Agent, Oral and Inhaled by or in consultation with an appropriate specialist (i.e., pulmonologist, cardiologist, or rheumatologist)

Q18. Does not have a contraindication to the prescribed drug.

Yes  No

Q19. For a non-preferred Pulmonary Hypertension Agent, Oral and Inhaled with a therapeutically equivalent brand or generic that is preferred on the PDL, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred therapeutically equivalent brand or generic that would not be expected to occur with the requested drug. See the PDL for the list of preferred Pulmonary Hypertension Agents, Oral and Inhaled at <https://papdl.com/preferred-drug-list>.

Yes  No

Q20. Additional Information:

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Prescriber Signature Date

v2026-06



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