



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

**Winrevair - Non-PDL**

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. 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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Yes

No

Q6. Is there documentation patient is Functional Class II, III, or IV at baseline prior to initiating therapy with Winrevair?

Yes

No

Q7. Is the medication prescribed by or in consultation with a cardiologist or pulmonologist?

Yes

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).

Yes

No

Q9. Does the patient have any contraindications to Winrevair (sotatercept-csrk)?

Yes

No

Q10. Additional Information:

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

v2026-06