

Pharmacy

PRIOR AUTHORIZATION FORM

For Prior Authorization, please fax to: (877) 974-4411 toll free, or (616) 942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Adcirca[®] (tadalafil)

Revatio[®] (sildenafil)

URGENT (life threatening)

Non-Urgent (standard review)

A claim involving "urgent care" applies when the standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

Provider Signature

Date

PRODUCT INFORMATION

- Adcirca[®] 20 mg
 Revatio[®] 20 mg
 Revatio[®] 10 mg/12.5 mL

Start Date: _____

Dosing frequency: _____

PRIORITY HEALTH PRECERTIFICATION REQUIREMENTS

Authorization for Adcirca[®] (tadalafil) or Revatio[®] (sildenafil) requires the following information to certify:

To certify this request, all of the following criteria must be met:

1. The medication is being used only for pulmonary arterial hypertension (PAH).
2. Patient must have a PAH classification that meets World Health Organization (WHO) Group 1 criteria.

Note: When approved, coverage for Adcirca[®] is limited to 40 mg daily. Revatio[®] is limited to a 60 mg total daily dose.

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION IS REQUIRED FOR REIMBURSEMENT

Authorization for Adcirca[®] (tadalafil) or Revatio[®] (sildenafil) requires the following information to certify:

1. What is the patient's diagnosis?

- a. Pulmonary arterial hypertension
b. Other: _____

Rationale for use: _____

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

2. What is the patient's WHO classification of PAH?

- a. Group 1
- 1.1 Idiopathic PAH
 - 1.2 Heritable
 - 1.2.1 BMPR2
 - 1.2.2 ALK1, endoglin
 - 1.2.3 Unknown
 - 1.3 Drug- and toxin-induced
 - 1.4 Associated with
 - 1.4.1 connective tissue disorder
 - 1.4.2 HIV infection
 - 1.4.3 Portal hypertension
 - 1.4.4 Congenital heart disease
 - 1.4.5 Schistosomiasis
 - 1.4.6 Chronic hemolytic anemia
 - 1.5 Persistent pulmonary hypertension of the newborn
- b. Group 2 (Adcirca[®] and Revatio[®] are not covered)
c. Group 3 (Adcirca[®] and Revatio[®] are not covered)
d. Group 4 (Adcirca[®] and Revatio[®] are not covered)
e. Group 5 (Adcirca[®] and Revatio[®] are not covered)

*** All fields must be complete and legible for Prior Authorization Review***

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX