

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

Remodulin[®] (treprostinil)

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

- Remodulin[®] 1 mg/mL solution for injection
 Remodulin[®] 2.5 mg/mL solution for injection
 Remodulin[®] 5 mg/mL solution for injection
 Remodulin[®] 10 mg/mL solution for injection

Start Date: _____

Dosing frequency: _____

BILLING INFORMATION

Place of administration:

- Provider's Office
 Outpatient Infusion Center
 Center Name: _____
 Home Infusion
 Agency Name: _____

Billing Options:

- Physician buy and bill
 Preferred Specialty Vendor
 Other: _____

 New
 Continuation

PRECERTIFICATION REQUIREMENTS

PRIORITY HEALTH PRECERTIFICATION REQUIREMENTS

Authorization for Remodulin[®] (treprostinil) require the following information to certify:

To certify this request, all of the following criteria must be met (authorization will be given for 3 months):

1. The medication is being used only for pulmonary arterial hypertension (PAH) for improvement of exercise capacity and to delay clinical worsening.
2. The patient's PAH classification meets World Health Organization Group 1 criteria with New York Heart Association (NYHA) Class II-IV symptoms.
3. Patient must have a documented therapeutic trial and clinical failure with both Flolan and Tracleer

To certify this request for continuation of therapy, the following criteria must be met:

1. After 2 months of initial therapy, results of six-minute walk must be submitted.

NEW REQUEST

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION IS REQUIRED FOR REIMBURSEMENT

Authorization for Remodulin[®] (treprostinil) require the following information to certify:

1. What is the patient's diagnosis?

- a. Pulmonary arterial hypertension
- b. Other: _____

ICD Code: _____

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 (Remodulin[®] is not covered)
- c. Group 3 (Remodulin[®] is not covered)
- d. Group 4 (Remodulin[®] is not covered)
- e. Group 5 (Remodulin[®] is not covered)

3. Does the patient have New York Heart Association (NYHA) class II, III, or IV symptoms?

- a. Yes
 b. No – Rationale for use: _____

4. Which of the following medications has the patient had a documented therapeutic trial and clinical failure with?

	Trial Dates	Outcome
a. <input type="checkbox"/> Flolan	_____	_____
b. <input type="checkbox"/> Tracleer	_____	_____

CONTINUATION OF THERAPY

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION IS REQUIRED FOR REIMBURSEMENT
 Authorization for Remodulin[®] (treprostinil) require the following information to certify:

Note: For patients who have not previously received precertification for initial therapy by Priority Health, information under the New Request section must also be provided for review.

1. What are the results of six-minute walk test after two months of Remodulin therapy? _____ft/meter

PRIORITY MEDICARE PLANS

Note: Priority Health Medicare applies CMS national and local coverage determination criteria when available for Part B drugs. If no national determination criteria or local coverage determination criteria is available for the state in which the member is receiving the services, the above prior authorization criteria must be met.

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

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX