PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial Individual (Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Orenitram ER® (treprostinil extended-release)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product:

☐ Orenitram ER 0.125 mg tablet

☐ Orenitram ER 0.125 mg tablet

☐ Orenitram ER 0.125 mg tablet

☐ Orenitram ER 0.125 mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Drug cost information

The wholesale acquisition cost for is $4.88 for every 0.125 mg of drug. The annual cost of treatment with this drug is will vary depending on the dosing, but may exceed $85,000.00.

Precertification Requirements

Before this drug is covered, patient must meet the following criteria (please submit applicable medical records):

1. Must have pulmonary arterial hypertension (PAH), World Health Organization (WHO) Group 1, AND all of the following:
    a. WHO functional Class II symptoms prior to initiation of Orenitram ER therapy
    b. Documentation confirming diagnosis such as pre-treatment right heart catheterization with the following results:
        i. MPAP ≥ 25mmHg
        ii. PCWP ≤ 15 mmHg
        iii. PVR > 3 Wood units
2. Must have tried sildenafil (generic Revatio)

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 12/2018

Last reviewed 01/2019

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Pulmonary arterial hypertension
- ☐ *Other – the patient's condition is:* _____

B. What World Health Organization Group category does this patient's clinical classification belong to?

- ☐ Group 1
- ☐ Group 2
- ☐ Group 3
- ☐ Group 4
- ☐ Group 5

C. What is the patient's WHO functional class?

- ☐ Class I
- ☐ Class II
- ☐ Class III
- ☐ Class IV

Additional information

WHO Group	Clinical classification	Etiology
1	Pulmonary arterial hypertension	▪ Idiopathic, familial, congenital heart abnormalities ▪ Connective tissue disorder ▪ Portal hypertension ▪ HIV ▪ Anorexigen-induced PAH
2	Pulmonary hypertension associated with left-sided heart disease	
3	Pulmonary hypertension associated with lung diseases or hypoxemia	
4	Chronic thromboembolic pulmonary hypertension	
5	Pulmonary hypertension with miscellaneous etiology	

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 12/2018
Last reviewed 01/2019