PriorityHealth

Medical 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.

Remodulin® (treprostinil)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Physician: _____ Phys. Phone: _____ Phys. Fax: _____

Physician Address: _____

Physician NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product:
- ☐ Remodulin 1 mg/mL solution
- ☐ Remodulin 2.5 mg/mL solution
- ☐ Remodulin 5 mg/mL solution
- ☐ Remodulin 10 mg/mL solution

Dose:_____ **Dose Frequency**:_____

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Date of next dose: _____

Place of administration:
- ☐ Physician's office
- ☐ Outpatient infusion
  - Facility: _____ NPI:_____ Fax:_____
- ☐ Home infusion
  - Facility: _____ NPI:_____ Fax:_____

Billing:
- ☐ Physician to buy and bill
- ☐ Facility to buy and bill
- ☐ Specialty Pharmacy
  - Pharmacy:_____ NPI:_____ Fax:_____

ICD-10 Diagnosis code(s): _____

Drug cost information

The wholesale acquisition cost for each 1 mg of drug is $58.95. The annual cost of treatment with this drug will vary depending on the dose used, but may exceed $141,480.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 12/2017

Last reviewed 12/2018

Precertification Requirements

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

1. Diagnosis of pulmonary arterial hypertension (PAH), (World Health Organization Group 1), AND
    a. Member has WHO functional Class II or greater symptoms prior to therapy initiation
    b. Documentation to support diagnosis, such as pre-treatment right heart catheterization with the following results:
        i. MPAP ≥ 25mmHg
        ii. PCWP ≤ 15 mmHg
        iii. PVR > 3 Wood units

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.

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	

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