UnitedHealthcare Community Plan

Pulmonary Arterial Hypertension (PAH) Agents - Washington
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No
   If yes, is there documentation supporting disease stability? ☐ Yes ☐ No

2. Indicate the diagnosis:
   - ☐ Pulmonary arterial hypertension (PAH) World Health Organization (WHO) Group 1 and
     - ☐ WHO Functional class II symptoms
     - ☐ WHO Functional class III symptoms
     - ☐ WHO Functional class IV symptoms
   - ☐ Persistent/recurrent chronic thromboembolic pulmonary hypertension (CTEPH) (WHO group 3 or 4)
   - ☐ Other. Specify _____

3. Has the patient tried a calcium channel blocker? ☐ Yes ☐ No
   If not, was it due to one of the following:
   - ☐ A contraindication to a calcium channel blocker
   - ☐ Patient had a negative response to acute vasoreactivity test (AVT)
   - ☐ Acute vasoreactivity test not indicated for the patient
   - ☐ Acute vasoreactivity test is contraindicated (SBP < 90 mmHg; cardiac index < 2 L/min/m2, or PH functional class IV)
   - ☐ Other. Explain _____

4. Will the requested therapy be used in combination with any of the following (check all that apply)?
   - ☐ Combination of phosphodiesterase inhibitor and soluble guanylate cyclase stimulator
   - ☐ Combination of selexipag and parenteral prostanoid
   - ☐ None of the above

5. **For Selexipag:** Does the patient have a history of failure, contraindication, or intolerance to an endothelin receptor antagonist? ☐ Yes ☐ No

6. Is this prescribed by or in consultation with a specialist in one of the following:
   ☐ Cardiology ☐ Pulmonology ☐ Other. Specify _____

CHART NOTES ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date