STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES TELEPHONE:
TELEPHONE: 1-866-409-8386 FAX: 1-866-759-4110

Pulmonary Arterial Hypertension
Clinical Prior Authorization (PA) Request Form
CT Medical Assistance Program
To Be Completed By Prescriber

Prescriber Information	Patient Information
Prescriber's NPI:	Patient's Medicaid ID Number:
Prescriber Name:	Patient Name:
Prescriber Subspecialty:	Patient DOB:
Phone ( )	Patient Primary ICD Diagnosis Code:
Fax ( )	
Prescription Information	
Drug, Strength, and Dosage Form Requested:	Frequency of Dosing:
□ New therapy □ Continuation	Quantity Requested:

Preferred Agents:	Non-Preferred Agents:	
ALYQ 20 MG TABLET*	ADCIRCA TABLET*	REVATIO SUSP & TABLET*
AMBRISENTAN TABLET	ADEMPAS TABLET	SILDENAFIL SUSPENSION*
SILDENAFIL 20 MG TABLET*	BOSENTAN TABLET	TADLIQ SUSPENSION*
TADALAFIL 20 MG TABLET (ADCIRCA)*	BOSENTAN TABL FOR SUSP	TRACLEER TABL FOR SUSP
TRACLEER 62.5 MG & 125 MG TABLET (BRAND PREFERRED)	LETAIRIS TABLET	TYVASO INHALATION
	OPSUMIT TABLET	TYVASO DPI INHALATION
	OPSYNVI TABLET	UPTRAVI TABLET
	ORENITRAM ER TABLET	YUTREPIA INHALATION
	ORENITRAM TITR KIT	

*(DX CODE REQUIRED)

Clinical Information

(attach supporting documentation, **required**)

Note: Using samples to initiate therapy does not meet authorization requirements

1. Provider has expertise in treating patients with pulmonary hypertension (as appropriate for diagnosis) o Please specify subspecialty:_____	□ Yes □ No

2. Is patient on current therapy with a nitrate agent? o Please specify agent:_____	□ Yes □ No
3. Is patient currently pregnant?	□ Yes □ No □ N/A
4. **For Phosphodiesterase-5 Inhibitors (PDE5) Requests:** Patient has trialed and failed ONE preferred phosphodiesterase-5 inhibitors agent for a minimum of 30 days **OR** documented contraindication and/or adverse drug event or adverse drug reaction (ADE/ADR) to therapy? o Preferred agents trialed: _____ o Trial Dates: _____ o Reason for Contraindication or Failure: _____	□ Yes □ No □ N/A
5. **For Endothelin Receptor Antagonists (ERA) Requests:** Patient has trialed and failed ONE preferred endothelin receptor antagonist agent for a minimum of 30 days **OR** documented contraindication and/or adverse drug event or adverse drug reaction (ADE/ADR) to therapy? o Preferred agents trialed: _____ o Trial Dates: _____ o Reason for Contraindication or Failure: _____	□ Yes □ No □ N/A

For Initial Approval:
Medication Requested and diagnosis of ONE of the following:

(attach supporting documentation, **required**)

Adcirca (tadalafil): • Patient has a documented diagnosis of pulmonary arterial hypertension **AND** • Failure to achieve desired therapeutic outcomes with a trial of ONE preferred oral phosphodiesterase-5 inhibitor (as outlined above in Question 4 of the Clinical Information section) **AND** • Documented medical reason why GENERIC preferred formulation cannot be used: _____	□ Yes □ No
Adempas (riociguat): • Patient has a documented diagnosis of pulmonary arterial hypertension **AND**	□ Yes □ No

• Failure to achieve desired therapeutic outcomes with a trial of ONE preferred oral phosphodiesterase-5 inhibitor (as outlined above in Question 4 of the Clinical Information section) **OR** • Patient has a documented diagnosis of Chronic thromboembolic pulmonary hypertension (CTEPH) **AND (for both indications):** o Provider attests to having met the REMS requirements for counseling and monitoring for female patients o Patient is NOT pregnant	
Bosentan Tablets (generic Tracleer): • Patient has a documented diagnosis of pulmonary arterial hypertension **AND** • Failure to achieve desired therapeutic outcomes with a trial of ONE preferred oral endothelin receptor antagonist (as outlined above in Question 5 of the Clinical Information section) **AND** • Provider attests to having met the REMS requirements for counseling and monitoring **AND** • Documented medical reason why BRAND preferred formulation cannot be used: _____	□ Yes □ No
Letairis (ambrisentan): • Patient has a documented diagnosis of pulmonary arterial hypertension **AND** • Failure to achieve desired therapeutic outcomes with a trial of ONE preferred oral endothelin receptor antagonist (as outlined above in Question 5 of the Clinical Information section) **AND** • Documented medical reason why GENERIC preferred formulation cannot be used: _____	□ Yes □ No
Opsumit (macitentan): • Patient has a documented diagnosis of pulmonary arterial hypertension **AND** • Failure to achieve desired therapeutic outcomes with a trial of ONE preferred oral endothelin receptor antagonist (as outlined above in Question 5 of the Clinical Information section)	□ Yes □ No
Opsynvi (macitentan and tadalafil):	□ Yes □ No

• Patient has a documented diagnosis of pulmonary arterial hypertension **AND** • Failure to achieve desired therapeutic outcomes with a trial of ONE preferred oral endothelin receptor antagonist (as outlined above in Question 5 of the Clinical Information section) *NOTE: Quantity limit of 1 tablet per day*	
Orenitram Titration Kit and ER (treprostinil diolamine): • Patient has a documented diagnosis of pulmonary arterial hypertension **AND** • Failure to achieve desired therapeutic outcomes with a trial of ONE oral endothelin receptor antagonist or oral phosphodiesterase-5 inhibitor (as outlined above in Question 4 and 5 of the Clinical Information section) **AND** • Patient does NOT have severe hepatic impairment; Child Pugh Class C (contraindication to therapy)	□ Yes □ No
Revatio Tablet (sildenafil): • Patient has a documented diagnosis of pulmonary arterial hypertension **AND** • Failure to achieve desired therapeutic outcomes with a trial of ONE preferred oral phosphodiesterase-5 inhibitor (as outlined above in Question 4 of the Clinical Information section) • Documented medical reason why GENERIC preferred formulation cannot be used: _____	□ Yes □ No
Revatio Suspension and Sildenafil Suspension: • Patient has a documented diagnosis of pulmonary arterial hypertension **AND** • Failure to achieve desired therapeutic outcomes with a trial of ONE preferred oral phosphodiesterase-5 inhibitor (as outlined above in Question 4 of the Clinical Information section) **AND** • Documented medical reason why preferred TABLET formulation cannot be used: _____ • **For Revatio Suspension**: Documented medical reason why GENERIC formulation cannot be used:_____	□ Yes □ No

NOTE: Trial and failure of a preferred dosage form is not required for patients unable to swallow solid dosage forms	
Tadliq Suspension (tadalafil): • Patient has a documented diagnosis of pulmonary arterial hypertension AND • Failure to achieve desired therapeutic outcomes with a trial of ONE preferred oral phosphodiesterase-5 inhibitor (as outlined above in Question 4 of the Clinical Information section) **AND** • Documented medical reason why preferred TABLET formulation cannot be used: _____ *NOTE: Trial and failure of a preferred dosage form is not required for patients unable to swallow solid dosage forms*	□ Yes □ No
Tracleer Tablet for Suspension (bosentan): • Patient has a documented diagnosis of pulmonary arterial hypertension **AND** • Failure to achieve desired therapeutic outcomes with a trial of ONE preferred oral endothelin receptor antagonist (as outlined above in Question 5 of the Clinical Information section) **AND** • Provider attests to having met the REMS requirements for counseling and monitoring **AND** • Documented medical reason why preferred BRAND TABLET formulation cannot be used: _____ *NOTE: Trial and failure of a preferred dosage form is not required for patients unable to swallow solid dosage forms*	□ Yes □ No
Tyvaso or Tyvaso DPI (treprostinil): • Patient has a documented diagnosis of pulmonary arterial hypertension associated with interstitial lung disease **OR** • Documented diagnosis of pulmonary arterial hypertension and inhaled prostacyclin is being selected as an add-on treatment due to clinical worsening on current regimen	□ Yes □ No
Uptravi (selexipag): • Patient has a documented diagnosis of pulmonary arterial hypertension **AND**	□ Yes □ No

• Failure to achieve desired therapeutic outcomes with a trial of ONE oral endothelin receptor antagonist or oral phosphodiesterase-5 inhibitor (as outlined above in Question 4 and 5 of the Clinical Information section) **AND** • Patient is NOT taking concomitant strong CYP2C8 inhibitors (e.g. gemfibrozil) (contraindication to therapy)	
Yutrepia (treprostinil): • Patient has a documented diagnosis of pulmonary arterial hypertension associated with interstitial lung disease **OR** • Documented diagnosis of pulmonary arterial hypertension and inhaled prostacyclin is being selected as an add-on treatment due to clinical worsening on current regimen	□ Yes □ No

Renewal Information

(attach supporting documentation, **required**)

Note: Using samples to initiate therapy does not meet renewal authorization requirements

• Has the patient previously met the required criteria set forth in Initial Approval Section above? o Previous Approved Prior Authorization Number: _____ o Approval Dates: _____	□ Yes □ No
• Patients' clinical response to treatment and ongoing safety has been documented and monitored	□ Yes □ No
• Prescriber attests that the patient has a continued need for therapy and is compliant with current regimen	□ Yes □ No
• For specific formulation requests: o **For brand requests when a therapeutically equivalent generic is preferred:** Provider must provide a documented medical reason the preferred generic formulation cannot be used _____ o **For generic requests when a therapeutically equivalent brand is preferred:** Provider must provide a documented medical reason the preferred brand formulation cannot be used _____ o **For non-preferred dosage or formulation requests:** Provider must provide a documented medical reason the preferred dosage or formulation cannot be used	

Please Note: Pharmacies should not be contacting prescribers to provide pre-signed PA forms or submitting pre-signed forms for PA, nor should prescribing providers be requesting that pharmacies perform PA activities for them. PA requests must originate from the prescriber, and only the prescriber should sign the form at the time of PA submission.
I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under section 17b-99 of the Connecticut General Statutes and sections 17-83k-1- to 17-83k-7, inclusive, of the Regulations of Connecticut State Agencies. I certify that the above-referenced member is a patient under my clinic's/practice's ongoing care. I understand that a prior authorization may not exceed one (1) year from the date of fill for non- controlled medications. Authorizations for Early Refill Requests are valid one time only.

Prescriber Signature*:_____ **Date:**_____

*** Mandatory (others may not sign for prescriber). In accordance with federal law, prescribers must be enrolled in the Connecticut Medical Assistance Program (CMAP). CMAP will not pay for prescriptions written by a non-enrolled provider.**