coordinated care

Pulmonary Arterial Hypertension (PAH) Agents

Please fax this completed form to (833) 645-2734 OR mail to: Pharmacy Services| 5 River Park Place East, Suite 210 | Fresno, CA 93720.
You can also complete online at CoverMyMeds.com.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number

Medication and strength	Directions for use	Qty/Days supply

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/m^2, 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

Pharmacy Services will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)