Pulmonary Arterial Hypertension (PAH) Agents

Please fax this completed form to (866) 399-0929 OR mail to: Envolve Pharmacy Solutions PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720.

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**: History of failure, contraindication or intolerance to an endothelin receptor antagonist

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

Envolve Pharmacy Solutions 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.)