

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Uptravi Fax back to: (833) 605-4407 Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process

| - TELAGE NOTE: Any information (patient, prese | Hoof, aray, labo) for braint, mograto, or not attached tribe acity the forton process. | | |
|--|--|------|--|
| Patient Name: | Prescriber Name: | | |
| Member Number: | Fax: Phone: | | |
| Date of Birth: | Office Contact: | | |
| Line of Business: Exchange - PA | NPI: State Lic ID: | | |
| Address: | Address: | | |
| City, State ZIP: | City, State ZIP: | | |
| Primary Phone: | Specialty/facility name (if applicable): | | |
| REQUEST FOR EXPEDITED REVIEW: By checking this box and the enrollee or the enrollee's ability to regain maximum function. | signing below, I certify that the standard review timeframe may seriously jeopardize the life or healt | h of | |
| Drug Name: | | | |
| Strength: | | | |
| Directions / SIG: | | | |
| | ncluding labs and information for this member that may support approval. swer the following questions and sign. | | |
| Q1. Is Uptravi being prescribed by or in consultation with a cardiologist, pulmonologist or practitioner at a Pulmonary Hypertension Association-Accredited center.? | | | |
| ☐ Yes | □ No | | |
| Q2. Is the patient 18 years of age or ol | der? | | |
| ☐ Yes | □ No | | |
| Q3. Does the patient have a diagnosis arterial hypertension (PAH)? | of World Health Organization (WHO) group 1 pulmonary | | |
| ☐ Yes | □ No | | |
| Q4. Has the diagnosis of PAH been co attach RHC report)? PAH is defined as | onfirmed by a complete right catheterization (RHC) (please | | |
| I. A mean pulmonary arterial pressure (mPAP) greater than 20 mmHg II. A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg III. A pulmonary vascular resistance (PVR) greater than 3 Wood units | | | |

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| Patient Name: | Prescriber Name: | |
|---|---|--|
| ☐ Yes | □No | |
| Q5. Does the patient have a World Health Organ limitation of physical activity but comfortable at redyspnea or fatigue, chest pain, or near syncope comfortable at rest. Less than ordinary activity conear syncope)? | est. Ordinary physical activity causes undue), or III (Marked limitation of physical activity and | |
| ☐ Yes | □ No | |
| Q6. Are pharmacy records or chart notes provided documenting trial of or inadequate response to two of the following alternatives (used alone or in combination): | | |
| I. Endothelin Receptor Antagonists (bosentan, ambrisentan, macitentan) II. Phosphodiesterase-5 inhibitors (sildenafil, tadalafil) III. Guanylate Cyclase stimulators (riociguat) | | |
| ☐ Yes | □ No | |
| Q7. Is there a treatment plan? | | |
| ☐ Yes | □ No | |
| Q8. Will Uptravi be used along with a strong CYP2C8 inhibitor (eg gemfibrozil)? | | |
| ☐ Yes | □No | |
| Q9. Does the patient have hepatic impairment (Child Pugh class B or greater) with lab monitoring and dose adjustments as needed? | | |
| ☐ Yes | □ No | |
| Q10. Additional Information: | | |
| | | |

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|---|------------------|--|
| Patient Name: | Prescriber Name: | |
| Prescriber Signature | Date | |

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