



Fax Completed Form To
1.833.404.2392

Prescriber Help Desk
1.833.587.2012

Online

covermy meds.com/main/prior-authorization-forms/

**Request for Prior Authorization
PULMONARY ARTERIAL HYPERTENSION AGENTS**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID # 	Patient name	DOB
Patient address		
Provider NPI 	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI 	Pharmacy fax	NDC

Prior authorization is required for agents used to treat pulmonary

hypertension. Preferred

Non-Preferred

- | | | | | | | |
|---------------------------------------|-------------------------------------|-----------------------------------|------------------------------------|--|-------------------------------------|------------------------------------|
| <input type="checkbox"/> Ambrisentan | <input type="checkbox"/> Sildenafil | <input type="checkbox"/> Adcirca | <input type="checkbox"/> Liquev | <input type="checkbox"/> Remodulin | <input type="checkbox"/> Tracleer | <input type="checkbox"/> Veletri |
| <input type="checkbox"/> Bosentan | <input type="checkbox"/> Tadalafil | <input type="checkbox"/> Adempas | <input type="checkbox"/> Opsumit | <input type="checkbox"/> Revatio | <input type="checkbox"/> Trepstinil | <input type="checkbox"/> Ventavis |
| <input type="checkbox"/> Epoprostenol | | <input type="checkbox"/> Flolan | <input type="checkbox"/> Opsynvi | <input type="checkbox"/> Sildenafil Susp | <input type="checkbox"/> Tyvaso | <input type="checkbox"/> Winrevair |
| | | <input type="checkbox"/> Letairis | <input type="checkbox"/> Orenitram | <input type="checkbox"/> Tadiq | <input type="checkbox"/> Upravi | |

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis:

- Pulmonary arterial hypertension
- Other (please specify) _____

Reason for use of Non-Preferred drug requiring prior approval: _____

Other medical conditions to consider: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
--	--------------------

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.