aetna®

MEDICARE FORM

Pulmonary Hypertension (Inhalation or Injectable Medication) Precertification Request

(All fields must be completed and legible for Precertification Review)

For Michigan MMP:
FAX: 1-844-241-2495
PHONE: 1-855-676-5772

For other lines of business:
Please use other form.

Note: Remodulin, Flolan, and Veletri are non-preferred. The preferred products are generic treprostinil and epoprostenol injectables. Generic treprostinil injectable does not require precertification. Generic epoprostenol injectable requires precertification.

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy, Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		DOB:	
Address:		City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:	
Patient Current Weight: _____ lbs or _____ kgs Patient Height: _____ inches or _____ cms			Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

C. PRESCRIBER INFORMATION

First Name:		Last Name:		*(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.	
Address:			City:	State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Office Contact Name:				Phone:	

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office ☐ Home
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy:
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: ☐ epoprostenol injection ☐ Flolan (epoprostenol injection) ☐ Remodulin (treprostinil injection) ☐ Revatio (sildenafil injection)
☐ Tyvaso (treprostinil inhalation solution) ☐ Veletri (epoprostenol injection) ☐ Ventavis (iloprost inhalation solution)

Dose: _____ **Frequency:** _____
HCPCS Code: _____ ☐ Implantable infusion pump ☐ External infusion pump ☐ IV ☐ SC

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: ☐ _____ ☐ Other: _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required):

Note: Remodulin, Flolan, and Veletri are non-preferred. The preferred products are generic treprostinil and epoprostenol injectables. Generic treprostinil injectable does not require precertification. Generic epoprostenol injectable requires precertification.

☐ Yes ☐ No Has the patient had prior therapy with Remodulin (treprostinil injection), Flolan (epoprostenol injectable), or Veletri (epoprostenol injectable) within the last 365 days?
☐ Yes ☐ No Has the patient had a trial, intolerance, or contraindication to generic treprostinil or epoprostenol injection?
☐ Yes ☐ No Does the patient have a diagnosis of Raynaud's phenomenon?
Please explain if there are any other medical reason(s) that the patient cannot use generic treprostinil or epoprostenol injection:

_____

_____

Please indicate the severity of the patient's symptoms using the World Health Organization (WHO) functional classification system:
Select one: ☐ I ☐ II ☐ III ☐ IV
☐ Yes ☐ No Was the mean pulmonary artery pressure documented by right heart catheterization or echocardiography?
→ Please indicate test and results: ☐ Echocardiography ☐ Right heart catheterization
At rest: _____ mmHg With exertion: _____ mmHg

Continued on next page

aetna®

MEDICARE FORM

Pulmonary Hypertension (Inhalation or Injectable Medication) Precertification Request

(All fields must be completed and legible for Precertification Review)

For Michigan MMP:
FAX: 1-844-241-2495
PHONE: 1-855-676-5772

For other lines of business:
Please use other form.

Note: Remodulin, Flolan, and Veletri are non-preferred. The preferred products are generic treprostinil and epoprostenol injectables. Generic treprostinil injectable does not require precertification. Generic epoprostenol injectable requires precertification.

Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

☐ Yes ☐ No Does the patient have a diagnosis of pulmonary hypertension?
→ Please identify the type of pulmonary hypertension:

☐ Chronic thromboembolic pulmonary hypertension (CTEPH) ☐ Hereditary PAH due to activin receptor-like kinase type 1 (ALK1),endoglin, mothers against decapentaplegic 9 (SMAD9), caveolin-1 (CAV1), or potassium channel subfamily K member-3 (KCNK3) ☐ Hereditary PAH due to bone morphogenetic protein receptor type 2 (BMPR2) ☐ Hereditary PAH due to unknown causes ☐ Idiopathic PAH (formerly primary pulmonary hypertension) ☐ PAH due to diseases that localize to small pulmonary arterioles, including drug and toxin-induced (e.g., anorectic agents (diet drugs)) ☐ PAH associated with congenital heart disease ☐ PAH associated with connective tissue diseases ☐ PAH associated with HIV infection ☐ PAH associated with portal hypertension ☐ PAH associated with schistosomiasis ☐ Persistent pulmonary hypertension of the newborn (PPHN) (such as associated with congenital diaphragmatic hernia) ☐ Pulmonary hypertension associated with pulmonary veno-occlusive disease (PVOD) or pulmonary capillary hemangiomatosis (PCH) ☐ Sarcoidosis associated with pulmonary hypertension ☐ Other:_____

☐ Yes ☐ No ☐ **N/A** Has the patient undergone an acute vasoreactivity test prior to initiation of therapy?
→ ☐ Yes ☐ No Is an acute vasoreactivity test contraindicated due to right heart failure, low systemic blood pressure, low cardiac index, or presence of severe (functional class IV) symptoms?
→ Please select: ☐ Low cardiac index ☐ Low systemic blood pressure ☐ Right heart failure ☐ Severe functional class IV symptoms

→ ☐ Yes ☐ No Did the patient have a **positive** acute vasoreactivity test result (defined as a decrease in mPAP (mean pulmonary artery pressure) at least 10 mmHg to an absolute level of less than 40 mgHg without a decrease in cardiac output)?
→ ☐ Yes ☐ No Does the patient have a documented trial and failure of a calcium channel blocker (dihydropyridine or diltiazem)?
→ ☐ Yes ☐ No Does the patient have a contraindication to a calcium channel blocker (e.g., right heart failure, hemodynamic instability)?

For Initiation Requests (clinical documentation required):

Revatio (sildenafil injection)

☐ Yes ☐ No Is the patient concurrently on organic nitrates (e.g., isosorbide mononitrate, isosorbide dinitrate, nitroglycerin)?
☐ Yes ☐ No Is the patient concurrently on guanylate cyclase (GC) stimulators (e.g., Adempas (riociguat))?

For Continuation of Therapy Requests (clinical documentation required):

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples?
☐ Yes ☐ No Is there clinical documentation indicating disease stability or improvement?
→ Please select: ☐ Disease stability ☐ Disease improvement

For Revatio (sildenafil injection) only:

☐ Yes ☐ No Is the patient concurrently on organic nitrates (e.g., isosorbide mononitrate, isosorbide dinitrate, nitroglycerin)?
☐ Yes ☐ No Is the patient concurrently on guanylate cyclase (GC) stimulators (e.g., Adempas (riociguat))?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.