Step Therapy: PAH Agents

Remodulin (treprostinil) J3285, Tyvaso (treprostinil) J7686, Ventavis (iloprost) Q4074 are non-preferred. Preferred drugs are:, Flolan / Veletri (epoprostenol sodium) J1325

Prior Authorization Request
Medicare Part B Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

☐	**Standard Request– (72 Hours)**	☐	**Urgent Request** (standard time frame could place the member's life, health or ability in serious jeopardy)
	Date Requested ___________________		
	Requestor ____________________ Clinic name: ___________________ Phone / Fax		

MEMBER INFORMATION

*Name:____________________________________ *ID#:_____________________ *DOB:_____________________

PRESCRIBER INFORMATION

*Name:_________________________________ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:______________________

*Address:____ *Fax:________________________

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name:___________________________________ Phone:____________________________

*Address:____ Fax:______________________________

PROCEDURE / PRODUCT INFORMATION

HCPC Code	Name of Drug	Dose (Wt: _____ kg Ht:______)	Frequency	End Date if known

☐ **Self-administered** ☐ **Provider-administered** ☐ **Home Infusion**

☐Chart notes attached. **Other important information:**____

Diagnosis: ICD10: _________ **Description**: ____

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

☐ New Start or Initial Request: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Approval" and attests the member meets ALL required PA criteria.**

If not, please provide **clinical rationale** for formulary exception: ____
____

☐ Continuation Requests: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Continuation" and attests the member meets ALL required PA Continuation criteria.**

☐ Patient had an adequate response or significant improvement while on this medication.

If not, please provide clinical rationale for continuing this medication: ______________________________________
____

ACKNOWLEDGEMENT

Request 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. THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

Prior Authorization Group – Pulmonary Arterial Hypertension Agents PA

Drug Name(s):

TYVASO **REMODULIN**
TREPROSTINIL **VENTAVIS**
ILOPROST
VELETRI **FLOLAN** **EPOPROSTENOL**

Criteria for approval of Prior Authorization Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Member has tried and failed at least ONE of the formulary alternatives: **Flolan / Veletri (epoprostenol sodium)** OR
   - There is clinical documentation stating formulary alternatives are contraindicated.
3. Drug is being used appropriately per MCG GUIDELINES, CMS recognized compendia, authoritative medical literature, evidence-based guidelines and/or accepted standards of medical practice.
4. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.

- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:
N/A

Prescriber Restrictions:
N/A

Coverage Duration:
Approvals will be for 12 months

FDA Indications:
Tyvaso, Remodulin, Flolan, Veletri

- Interstitial lung disease - Pulmonary hypertension, WHO Group 3 (Tyvaso and Remodulin only)
- Pulmonary arterial hypertension, In patients requiring transition from epoprostenol sodium (Tyvaso and Remodulin only)
- Pulmonary arterial hypertension, WHO Group I

Ventavis

- Pulmonary arterial hypertension

Off-Label Uses:
Ventavis

- Radiographic contrast agent nephropathy; Prophylaxis
- Transient osteoporosis

Flolan, Veletri

- Angina pectoris
- Operation on heart, with cardiopulmonary bypass – Pulmonary hypertension
- Pulmonary hypertension – Vasoreactivity test
- Eisenmenger's syndrome

CLINICAL / CMS ONLY

Age Restrictions:

Safety and effectiveness of ocrelizumab have not been established in pediatric patients

Other Clinical Considerations:

N/A

Resources:

https://www.micromedexsolutions.com/micromedex2/librarian/CS/D42E9F/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/7E5DC6/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.DoIntegratedSearch?SearchTerm=Treprostinil&fromInterSaltBase=true&UserMdxSearchTerm=%24userMdxSearchTerm&false=null&=null#

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https://careweb.careguidelines.com/ed24/ac/ac04_050.htm

https://careweb.careguidelines.com/ed24/ac/ac04_046.htm

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