ProCare Rx

Uptravi®

Ticket #: _____ Request Date: _____ Request Time: _____

Uptravi® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Pulmonary arterial hypertension (PAH)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Does the patient have pulmonary arterial hypertension (PAH) that is symptomatic? ❑ **Yes** ❑ **No**

Was the diagnosis of PAH confirmed by right heart catheterization? ❑ **Yes** ❑ **No**

Is the patient currently on any therapy for the diagnosis of PAH? ❑ **Yes** ❑ **No**

Select if the patient has history of failure, contraindication, or intolerance to the following:

- ❑ Adempas (riociguat)
- ❑ Endothelin receptor antagonist [e.g., Letairis (ambrisentan), Opsumit (macitentan), or Tracleer (bosentan)]
- ❑ PDE-5 inhibitor (i.e., Adcirca, Revatio)

Is this request for continuation of prior Uptravi therapy? ❑ **Yes** ❑ **No**

Will Uptravi be used in combination with a prostanoid/prostacyclin analogue [e.g., Flolan/Veletri (epoprostenol), Ventavis (iloprost), Tyvaso (treprostinil)]? ❑ **Yes** ❑ **No**

Is the requested medication prescribed by or in consultation with a pulmonologist or cardiologist? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following questions:

Is there documentation the patient has had a positive clinical response to therapy? ❑ **Yes** ❑ **No**

Will Uptravi be used in combination with a prostanoid/prostacyclin analogue [e.g., Flolan/Veletri (epoprostenol), Ventavis (iloprost), Tyvaso (treprostinil)]? ❑ **Yes** ❑ **No**

Quantity Limit Requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes

❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

❑ Requested strength/dose is not commercially available

❑ Other: _____

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Authorized Medical Signature:	
Telephone:	Date:

When Completed Return To:

ProCare PBM Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

Please note: This request may be denied unless all required information is received.

Office use only: Uptravi_Comm_2017Dec