



Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
 P.O. Box 2586, Worcester, MA 01613-2586
Fax: (877) 208-7428 **Phone:** (800) 745-7318

Pulmonary Arterial Hypertension Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at www.mass.gov/druglist.

Member information

Last name _____ First name _____ MI _____
 MassHealth member ID # _____ Date of birth _____
 Gender (Check one.) F M Member's place of residence home nursing facility

Medication information

Medication requested

- | | |
|--|---|
| <input type="checkbox"/> Adempas (riociguat) | <input type="checkbox"/> tadalafil |
| <input type="checkbox"/> ambrisentan | <input type="checkbox"/> treprostinil injection |
| <input type="checkbox"/> bosentan | <input type="checkbox"/> Tyvaso (treprostinil inhalation) |
| <input type="checkbox"/> Opsumit (macitentan) | <input type="checkbox"/> Uptravi (selexipag) |
| <input type="checkbox"/> Orenitram (treprostinil extended-release tablet) | <input type="checkbox"/> Veletri (epoprostenol) |
| <input type="checkbox"/> sildenafil 20 mg tablet – Section I only required | <input type="checkbox"/> Ventavis (iloprost inhalation) |
| <input type="checkbox"/> sildenafil oral suspension | <input type="checkbox"/> Other* _____ |

** If request is for a non-preferred brand name or generic product, please attach supporting documentation (e.g., copies of medical records and/or office notes regarding adverse reaction or inadequate response to the preferred product).*

Dose, frequency, and duration of medication requested _____

Is the member stabilized on the requested medication?
 Yes. Please provide start date. _____ No

Section I. Please complete for all requests.

Indication (Check all that apply.)

- Chronic thromboembolic pulmonary hypertension (CTEPH) Pulmonary arterial hypertension
 Other (Please indicate.) _____

Please indicate prescriber specialty below.

- Cardiology Pulmonology Other (Please indicate.) _____

Please attach copies of medical records and/or office notes from cardiologist or pulmonologist regarding the diagnosis.

Section II. Please also complete for tadalafil requests.

Has the member tried sildenafil 20 mg tablet?

Yes. Please provide the following information.*

Dates/duration of use _____

Did the member experience any of the following? Adverse reaction Inadequate response

Briefly describe details of adverse reaction or inadequate response.

 No. Does the member have a contraindication to sildenafil? Please explain.

Section III. Please also complete for Adempas requests.

1. Will Adempas be administered concurrently with a phosphodiesterase-5 inhibitor (sildenafil or tadalafil)?

Yes. Please explain below. No

2. For members with CTEPH, please describe surgical history and/or prognosis.

3. For members with pulmonary arterial hypertension, has the member tried sildenafil or tadalafil?

Yes. Please provide the following information.*

Drug name _____ Dates/duration of use _____

Did the member experience any of the following? Adverse reaction Inadequate response

Briefly describe details of adverse reaction or inadequate response.

 No. Does the member have a contraindication to sildenafil or tadalafil? Please explain.

Section IV. Please also complete for Orenitram, treprostinil injection, Tyvaso, and Ventavis requests.

Has the member tried epoprostenol?

Yes. Please provide the following information.*

Dates/duration of use _____

Did the member experience any of the following? Adverse reaction Inadequate response

Briefly describe details of adverse reaction or inadequate response.

 No. Does the member have a contraindication to epoprostenol? Please explain.

Section V. Please also complete for Veletri requests.

Please provide clinical rationale for not using generic epoprostenol.

Section VI. Please also complete for sildenafil oral suspension requests.

Please provide clinical rationale for not using sildenafil tablets.

* Please attach a letter documenting additional trials as necessary.

Section VII. Please also complete for bosentan for suspension requests.

Please indicate: Member's current weight _____ Date _____

Section VIII. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

Prescriber information

Last name* _____ First name* _____ MI _____
NPI* _____ Individual MH Provider ID _____
DEA No. _____ Office Contact Name _____
Address _____ City _____ State _____ Zip _____
E-mail address _____
Telephone No.* _____ Fax No.* _____

* *Required*

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____ Date _____