Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Ambrisentan - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the prescriber a cardiologist, pulmonologist, or Practitioner at a Pulmonary Hypertension Association-accredited center?

☐ Yes ☐ No

Q2. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q3. Is the patient a female?

☐ Yes ☐ No

Q4. Is the patient pregnant?

☐ Yes ☐ No

Q5. Is the patient able to get pregnant?

☐ Yes ☐ No

Q6. Will the patient use reliable forms of contraception?

☐ Yes ☐ No

Q7. Will the patient have pregnancy tests before therapy initiated and monthly during therapy?

☐ Yes ☐ No

Q8. Does the patient have a contraindication such as idiopathic pulmonary fibrosis?

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Patient Name:	**Prescriber Name:**

☐ Yes ☐ No

Q9. Does the patient have a diagnosis of World Health Organization (WHO) Group 1 pulmonary arterial hypertension (PAH)?

☐ Yes ☐ No

Q10. Has the diagnosis of pulmonary arterial hypertension (PAH) been confirmed by a complete right heart catheterization (RHC)? If Yes, please attach documentation. PAH is defined as: A) A mean pulmonary arterial pressure (mPAP) greater than 20 mmHgB) A pulmonary capillary wedge pressure/ left ventricular end-diastolic pressure (PCWP/LVEDP) less than or equal to 15 mmHg C) A pulmonary vascular resistance (PVR) greater than 3 Wood units

☐ Yes ☐ No

Q11. Will the patient's hemoglobin level be monitored?

☐ Yes ☐ No

Q12. Additional Information:

Q13. Requested Duration:

☐ 12 Months ☐ Other

_____ _____

Prescriber Signature Date

2023 Medicare Prior Authorization Request