

HEALTH PARTNERS PLANS PRIOR AUTHORIZATION REQUEST FORM

Adempas - Medicare

Phone: 215-991-4300 Fax back to: 866-240-3712

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.

PLEASE NOTE. Any information (patient, prescriber, dru	g, labs) left blank, megible, or not attached will bela	Title review process.	
Patient Name:	Prescriber Name:	Prescriber Name:	
HPP Member Number:	Fax: Phone:		
Date of Birth:	Office Contact:		
Patient Primary Phone:	NPI: PA PROMIS	Se ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	Specialty Pharmacy (if applicable):	Specialty Pharmacy (if applicable):	
Drug Name:	Strength:	Strength:	
Quantity:	Refills:		
Directions:			
Diagnosis Code: Diagnosis:			
HPP's maximum approval time is 12 months but may be less depending on the drug.			
The committee of the control of the			
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 Adempas being prescribed by a cardiologist or pulmonologist?			
☐ Yes ☐ No			
Q2. Is the patient 18 years of age or older?			
☐ Yes ☐ No			
Q3. Is the patient female and is of reproductive potential?			
☐ Yes ☐ No			
Q4. Did the patient have a negative pregnancy test and enroll in the manufacturer's risk evaluation and mitigation strategy (REMS) program prior to initiating Adempas? If yes, include confirmation of a negative pregnancy test prior to start of therapy and enrollment in the manufacturer's REMS program.			
☐ Yes	□ No		
Q5. Does the member have the diagnosis of World Health Organization (WHO) Group 1 pulmonary arterial hypertension (PAH)?			
Yes	□No		
Q6. Has the diagnosis of PAH been confirmed by a complete right catheterization (RHC) (please attach RHC report)? PAH is defined as: I. A mean pulmonary arterial pressure (mPAP) greater than 20 mmHg; II. A pulmonary capillary wedge pressure left ventricular end-diastolic pressure (PCWP/ LVEDP) less than or equal to 15 mmHg; III. A pulmonary vascular resistance (PVR) greater than 3 Wood units			
☐ Yes	□ No		

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document



HEALTH PARTNERS PLANS PRIOR AUTHORIZATION REQUEST FORM

Adempas - Medicare

Phone: 215-991-4300 Fax back to: 866-240-3712

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:	
Q7. Does the patient have WHO functional class II (Slight limitation of physical activity but comfortable at rest. Ordinary physical activity causes undue dyspnea of fatigue, chest pain, or near syncope) or III (Marked limitation of physical activity and comfortable at rest. Less than ordinary activity causes undue dyspnea or fatigue, chest pain, or near syncope)?		
☐ Yes	□ No	
Q8. Does the member have the diagnosis of World Health Organization (WHO) Group 4 PAH?		
☐ Yes	□ No	
Q9. Is there documentation confirming the diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH) and verifying patient has recurrent or persisting pulmonary hypertension following pulmonary thromboendarterectomy or inoperable CTEPH?		
☐ Yes	□ No	
Q10. Will Adempas be used with nitrates, nitric oxide donors, or phosphodiesterase inhibitors?		
☐ Yes	□ No	
Q11. Is there a treatment plan?		
☐ Yes	□ No	
Q12. Requested Duration:		
☐ 12 months	Other:	
Prescriber Signature	Date	

Updated for 2023