Health Partners
A part of Jefferson Health Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Winrevair - Non PDL

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:	
HPP HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Patient Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	

HPP's maximum approval time is 12 months but may be less depending on the drug.

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 patient prescribed a dose and duration of therapy consistent with the FDA approved package labeling?

☐ Yes ☐ No

Q2. Is this a request for a renewal? If YES, go to question 3. If NO, go to question 4

☐ Yes ☐ No

Q3. Is there documentation of positive clinical response and/or tolerance to the requested medication?

☐ Yes ☐ No

Q4. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q5. Is there documentation of a diagnosis of pulmonary arterial hypertension (PAH) WHO Group I confirmed by right heart catheterization with all of the following?

a. Mean pulmonary arterial pressure (mPAP) > 20 mmHg

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Patient Name:	Prescriber Name:

b. Pulmonary capillary wedge pressure (PCWP) = 15 mmHg
c. Pulmonary vascular resistance (PVR) = 3 Wood units

☐ Yes ☐ No

Q6. Is there documentation patient is Functional Class II, III, or IV at baseline prior to initiating therapy with Winrevair?

☐ Yes ☐ No

Q7. Is the medication prescribed by or in consultation with a cardiologist or pulmonologist?

☐ Yes ☐ No

Q8. For patients newly starting therapy with Winrevair, ONE of the following:

a. The patient is currently receiving at least two other PAH therapies from the following drug classes: Endothelin receptor antagonist (e.g., Letairis, Opsumit, Tracleer); Phosphodiesterase-5 inhibitor (e.g., Adcirca, Revatio); Soluble guanylate cyclase stimulator (e.g., Adempas); Prostacyclin analog (e.g., Flolan, Orenitram, Remodulin, Tyvaso, Veletri, Ventavis): Prostacyclin receptor agonist (e.g., Uptravi).

b. The patient is currently receiving at least one other PAH therapy from the drug classes listed in 9.a. and the prescriber attests the member is unable to tolerate/not a candidate for combination therapy).

☐ Yes ☐ No

Q9. Does the patient have any contraindications to Winrevair (sotatercept-csrk)?

☐ Yes ☐ No

Q10. Additional Information:

Prescriber Signature

Date

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