Jefferson Health Plans

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Phosphodiesterase 5 Inhibitors - Medicare

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

Jefferson Health 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 rheumatologist?

☐ Yes ☐ No

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

☐ Yes ☐ No

Q3. Will the patient take sildenafil in combination with either of the following: A) Organic nitrates, or B) Guanylate cyclase (GC) stimulators (e.g., riociguat)?

☐ Yes ☐ No

Q4. Does the patient have a diagnosis of World Health Organization (WHO) Group 1 pulmonary arterial hypertension (PAH)?

☐ Yes ☐ No

Q5. Has the diagnosis of PAH been confirmed by a complete right heart catheterization (RHC) and are the RHC results provided ? PAH defined as: A. A mean pulmonary artery pressure (mPAP) greater than 20 mmHg; B. A pulmonary capillary wedge Pressure/ left ventricular end diastolic pressure (PCWPLVEDP) less than or equal to 15 mmHg; C. A pulmonary vascular resistance (PVR) greater than 3 Wood units.

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q6. Does the patient have a diagnosis of Raynaud's phenomenon?

☐ Yes ☐ No

Q7. Has the patient had an inadequate response or intolerance to one calcium channel blocker?

☐ Yes ☐ No

Q8. Additional Information:

Q9. Requested Duration:

☐ 12 months ☐ Other

Prescriber Signature

Date

2024 Medicare Prior Authorization Request