AMIDA CARE
ABOVE AND BEYOND FOR YOU

PRIOR AUTHORIZATION REQUEST: Pulmonary Arterial Hypertension (PAH) Treatment

Please fax form to Amida Care: 1-646-786-0997

MEMBER INFORMATION	
Name:	Medicaid ID#:
Phone #:	Address:
Current weight: _____ lb or _____ kg	Height: _____ in or _____ cm
PRESCRIBER INFORMATION	
Name:	NPI:
Office Phone #:	Office Fax #:
Address:	
Contact Person:	
Prescriber Specialty: ☐ Cardiologist ☐ Pulmonologist ☐ Other:_____	

REQUESTED MEDICATION	
Medication	**Dose/Frequency (per month)**
Please indicate type of request: ☐ New treatment ☐ Continuation of therapy	

CLINICAL INFORMATION

1. What is this patient's Pulmonary Hypertension (PH) WHO Group Classification? ☐ I ☐ II ☐ III ☐ IV ☐ V
   - ☐ Primary ICD-10 code: _____
   - ☐ Other relevant diagnoses: _____
2. Attach documentation of **all** lab results to support your medication request. Please be sure to also include the following:
   - ☐ Pre-treatment right heart catheterization or ECHO
   - ☐ Vasoreactivity test – If contraindicated, please include reasoning in documentation provided
   - ☐ Documentation of current hemodynamic status to help guide choice of medication therapy
   - ☐ Pulmonary Artery Pressure (PAP) ≥25 mmHg
   - ☐ Pulmonary Capillary Wedge Pressure ≤15 mmHg
   - ☐ Pulmonary Vascular Resistance >3 wood units
   - ☐ Pre-treatment 6-minute-walking-distance: _____
   - ☐ Oxygen saturation (SpO_2): _____
3. Is this patient currently being treated with the requested medication? ☐ Yes ☐ No
   a. If yes, when was this medication started? Date: ___/___/___
   If yes, please include documentation of disease stability or improvement.
4. Was a calcium channel blocker tried in this patient? (Please list outcomes in #5) ☐ Yes ☐ No ☐ N/A
5. Previous PAH therapy prescribed and outcomes:

Previous Therapy	Dates	Outcome(s)

   ☐ If more room is needed, please attach additional medication therapy list.
6. Is the request for a PDE5-inhibitor? ☐ Yes ☐ No – if no, proceed to question 7.
   a. Is this patient concurrently on a guanalate cyclase stimulator (e.g. riociguat)? ☐ Yes ☐ No
   b. Is this patient concurrently on organic nitrates (e.g. nitroglycerin)? ☐ Yes ☐ No
7. Does this patient have a concurrent diagnosis of HIV? ☐ Yes ☐ No – if no, proceed to question 8.
   a. Has the patient been on stable antiretroviral (ARV) therapy (e.g. for at least 3 months)? ☐ Yes ☐ No
   b. Has the regimen been reviewed for any drug-drug interactions (e.g. ritonavir + PDE-5 inhibitor)? ☐ Yes ☐ No

ADDITIONAL SUPPORT INFORMATION

8. ***Amida Care resources are available to support member adherence and lifestyle modification. Please check below to request any additional type of support or services for member (e.g. connection to care, transportation, treatment navigation, housing assistance, adherence outreach, support groups, etc.):***
   ☐ Additional support needed for member by Amida Care (Please specify type of support needed):
   _____
   _____

Please call 646-757-7979 or email dgreenidge@amidacareny.org M-F, 9:00-4:30PM with any questions or for info.

_____ _____
Prescriber/Authorized Signature *Date*

AMIDA CARE
ABOVE AND BEYOND FOR YOU

PRIOR AUTHORIZATION REQUEST: Pulmonary Arterial Hypertension (PAH) Treatment

Please fax form to Amida Care: 1-646-786-0997