Remodulin, treprostinil

HMSA - Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-237-5512**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Patient's Phone Number: _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*ft* _____*inches*

Indicate where the drug is being dispensed:

❑ Office ❑ Outpatient Hospital ❑ Ambulatory Surgical ❑ Inpatient Hospital
❑ Off Campus Outpatient Hospital ❑ Urgent Care ❑ Emergency Room ❑ Birthing Center
❑ Military Facility ❑ Skilled Nursing Facility ❑ Nursing Facility ❑ Hospice
❑ Inpatient Psychiatric ❑ Psychiatric Residential Treatment ❑ End Stage Renal Facility
❑ Psychiatric Facility ❑ Pharmacy ❑ Other

Indicate where the drug is being administered:

❑ Ambulatory surgical ❑ Home ❑ Inpatient hospital ❑ Office
❑ Outpatient Hospital ❑ Pharmacy

Criteria Questions:

1. What drug is being prescribed? ❑ Remodulin ❑ treprostinil
2. What is the diagnosis?
   ❑ Pulmonary arterial hypertension (PAH)
   ❑ Other _____
3. What is the ICD-10 code? _____
4. Is the requested drug prescribed by or in consultation with a pulmonologist or cardiologist? ❑ Yes ❑ No

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

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CVS Caremark Specialty Programs ● 2969 Mapunapuna Place ● Honolulu, HI 96819
Phone: 1-808-254-4414 ● Fax: 1-866-237-5512 ● www.caremark.com

5. What is the World Health Organization (WHO) classification of pulmonary hypertension?
   - ❑ **WHO Group 1** (Pulmonary arterial hypertension)
   - ❑ **WHO Group 2** (Pulmonary hypertension owing to left heart disease)
   - ❑ **WHO Group 3** (Pulmonary hypertension owing to lung disease and/or hypoxia)
   - ❑ **WHO Group 4** (Chronic thromboembolic pulmonary hypertension)
   - ❑ **WHO Group 5** (Pulmonary hypertension with unclear multifactorial mechanisms)

6. Has PAH been confirmed by right heart catheterization? ❑ Yes ❑ No *If No, skip to #10*

7. What is the pretreatment mean pulmonary arterial pressure at rest? ***ACTION REQUIRED: Please attach documentation*** _____ mmHg

8. What is the pretreatment pulmonary capillary wedge pressure? ***ACTION REQUIRED: Please attach documentation*** _____ mmHg

9. What is the pretreatment pulmonary vascular resistance? ***ACTION REQUIRED: Please attach documentation*** _____ Wood units *No further questions*

10. Is the patient an infant less than one year of age? ❑ Yes ❑ No

11. Has Doppler echocardiogram been performed to diagnose PAH? ***ACTION REQUIRED: Please attach documentation*** ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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