Treprostinil-Remodulin

HMSA Medicare Advantage - 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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

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

What is the ICD-10 code? _____

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

 Treprostinil-Remodulin HMSAMED C26861-A – 03/2025.

Criteria Questions:

1. What is the diagnosis?

❒ Pulmonary hypertension (PH), *Continue to #10*

❒ Severe peripheral ischemia, *Continue to #2*

❒ Other, *No Further Questions*

2. Is the patient currently receiving therapy with the requested medication?

❒ Yes, *Continue to #3*

❒ No, *No Further Questions*

3. Is the patient currently receiving the requested medication through a paid pharmacy or medical benefit?

❒ Yes, *Continue to #4*

❒ No, *No Further Questions*

❒ Unknown, *No Further Questions*

Continuation

4. Has the patient received clinical benefit from therapy with the requested medication defined as either disease stability or disease improvement?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Pulmonary hypertension

10. Is the pulmonary hypertension secondary to pulmonary venous hypertension (e.g., left-sided atrial or ventricular disease, left-sided valvular heart disease, etc.) or disorders of the respiratory system (e.g., COPD, interstitial lung disease, obstructive sleep apnea or other sleep disordered breathing, alveolar hypoventilation disorders, etc.)?

❒ Yes, *Continue to #11*

❒ No, *Continue to #11*

11. Does the member have primary pulmonary hypertension or pulmonary hypertension, which is secondary to one of the following: connective tissue disease, thromboembolic disease of pulmonary arteries, human immunodeficiency virus (HIV) infection, cirrhosis, diet drugs, congenital left to right shunts, etc.?

❒ Yes, *Continue to #12*

❒ No, *Continue to #12*

12. Has the pulmonary hypertension progressed despite maximal medical and/or surgical treatment of the identified condition?

❒ Yes, *Continue to #13*

❒ No, *Continue to #13*

13. Is the mean pulmonary artery pressure greater than 25 mmHg at rest or greater than 30 mmHg with exertion?

❒ Yes, *Continue to #14*

❒ No, *Continue to #14*

14. Does the patient have significant symptoms from the pulmonary hypertension (i.e., severe dyspnea on exertion, and either fatigability, angina, or syncope)?

❒ Yes, *Continue to #15*

❒ No, *Continue to #15*

15. Has the patient failed treatment with oral calcium channel blocking agents or has treatment with oral calcium channel blocking agents been considered and ruled out?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

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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