Health Partners Plans

HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

Adempas - Medicare

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

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:**	
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 Adempas being prescribed by or in consultation with a cardiologist or pulmonologist?

☐ Yes ☐ No

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

☐ Yes ☐ No

Q3. Is the patient female and of reproductive potential?

☐ Yes ☐ No

Q4. Did the patient have a negative pregnancy test and enroll in the manufacturer's risk evaluation and mitigation strategy (REMS) program prior to initiating Adempas?

If yes, include confirmation of a negative pregnancy test prior to start of therapy and enrollment in the manufacturer's REMS program.

☐ Yes ☐ No

Q5. Does the patient have a diagnosis of World Health Organization (WHO) Group 1 pulmonary arterial hypertension (PAH)?

☐ Yes ☐ No

Q6. Has the diagnosis of pulmonary arterial hypertension (PAH) been confirmed by a complete right heart catheterization (RHC)? If yes, please attach RHC report.

PAH is defined as:

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Patient Name:	**Prescriber Name:**

A) Mean pulmonary arterial pressure (mPAP) greater than 20 mmHg
B) A pulmonary capillary wedge pressure/ left ventricular end-diastolic pressure (PCWP/LVEDP) less than or equal to 15 mmHg
C) A pulmonary vascular resistance (PVR) greater than 3 Wood units

☐ Yes ☐ No

Q7. Does the patient have a World Health Organization (WHO) functional class of II (Slight limitation of physical activity but comfortable at rest. Ordinary physical activity causes undue dyspnea or fatigue, chest pain, or near syncope) OR III (Marked limitation of physical activity and comfortable at rest. Less than ordinary activity causes undue dyspnea or fatigue, chest pain, or near syncope)?

☐ Yes ☐ No

Q8. Does the patient have a diagnosis of World Health Organization (WHO) Group 4 pulmonary arterial hypertension (PAH)?

☐ Yes ☐ No

Q9. Is there documentation confirming the diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH) and verifying the patient has recurrent or persisting pulmonary hypertension following pulmonary thromboendarterectomy or inoperable CTEPH?

☐ Yes ☐ No

Q10. Will Adempas be used with nitrates, nitric oxide donors, or phosphodiesterase-5 inhibitors?

☐ Yes ☐ No

Q11. Is there a treatment plan?

☐ Yes ☐ No

Q12. Additional Information:

Q13. Requested Duration:

☐ 12 Months

Prescriber Signature

Date

2021 Medicare Prior Authorization Request