JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Remodulin, treprostinil

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4.

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

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

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

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

Drug Information:

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

Send completed form to: Priority Partners Fax: 1-866-212-4756

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.jhhc.com

Criteria Questions:

1. What drug is being prescribed? ❑ Remodulin ❑ treprostinil
2. What is the diagnosis?
   ❑ Pulmonary arterial hypertension (PAH)
   ❑ Other, please specify _____
3. What is the ICD-10 code? _____
4. Is the requested medication prescribed by or in consultation with a pulmonologist or cardiologist? ❑ Yes ❑ No
5. Is the patient currently receiving treatment with the requested medication? ❑ Yes ❑ No *If No, skip to #8*
6. Is the patient currently receiving the requested medication through a paid pharmacy or medical benefit?
   ❑ Yes ❑ No ❑ Unknown *If No or Unknown, skip to #8*
7. Is the patient experiencing benefit from therapy as evidenced by disease stability or disease improvement?
   ❑ Yes ❑ No *No further questions*
8. 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)
9. Has the diagnosis been confirmed by right heart catheterization? ❑ Yes ❑ No *If No, skip to #13*
10. What is the pretreatment mean pulmonary arterial pressure (mPAP) at rest? _____ mmHg
11. What is the pretreatment pulmonary capillary wedge pressure (PCWP)? _____ mmHg
12. What is the pretreatment pulmonary vascular resistance (PVR)? _____ Wood units *No further questions*
13. Is the patient an infant less than one year of age? ❑ Yes ❑ No
14. Has Doppler echocardiogram been performed to confirm the diagnosis? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

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

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