# Ventavis

## 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 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**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Ventavis SGM 1648-A – 12/2022.

**Criteria Questions:**

1. What is the diagnosis?
   ❑ Pulmonary arterial hypertension (PAH)
   ❑ Other, please specify ____________________________________________
2. What is the ICD-10 code? _____________
3. Is the requested medication prescribed by or in consultation with a pulmonologist or cardiologist? ❑ Yes ❑ No
4. Is the patient currently receiving treatment with the requested medication? ❑ Yes ❑ No *If No, skip to #7*
5. Is the patient currently receiving the requested medication through a paid pharmacy or medical benefit?
   ❑ Yes ❑ No ❑ Unknown *If No or Unknown, skip to #7*
6. Is the patient experiencing benefit from therapy with the requested medication as evidenced by disease stability or disease improvement? ❑ Yes ❑ No *No further questions*
7. 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)
8. Has the diagnosis been confirmed by right heart catheterization? ❑ Yes ❑ No *If No, skip to #12*
9. What is the pretreatment mean pulmonary arterial pressure (mPAP) at rest? _____________ mmHg
10. What is the pretreatment pulmonary capillary wedge pressure (PCWP)? _____________ mmHg
11. What is the pretreatment pulmonary vascular resistance (PVR)? _____________ Wood units *No further questions*
12. Is the patient an infant less than one year of age? ❑ Yes ❑ No
13. 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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**Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076**

**Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.jhhc.com**