**Note**: Processing may be delayed if information submitted is illegible or incomplete.

If your fax includes the standardized fax form, only the **Enrollee Name**, **Date of Birth**, **Medicaid ID**, and **Clinical Criteria** need to be completed and faxed as an attachment to process your request. For diagnoses other than PAH, please call the Clinical Support Center at 1-877-309-9493 to request a prior authorization.

# ENROLLEE INFORMATION

**Enrollee’s Last Name: Enrollee’s First Name:**

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**Date of Birth: Enrollee’s Medicaid ID (2 letters, 5 numbers, 1 letter):**

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# PRESCRIBER INFORMATION

**Prescriber’s Last Name: Prescriber’s First Name:**

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**Contact Person:**

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**National Provider Identifier (NPI) Number:**

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**Office Phone Number: Office Fax Number:**

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# CLINICAL CRITERIA

1. Which drug are you requesting? (Document name, strength, directions, quantity, and number of refills.)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **PREFERRED DRUGS – PLEASE SELECT ONE** | | | | | |
|  | **Drug** | **Strength** | **Directions** | **Quantity** | **Refills** |
|  | sildenafil (generic for Revatio®) |  |  |  |  |
|  | Tadalafil (generic for Adcirca®) |  |  |  |  |
| **NON-PREFERRED DRUGS - PLEASE SPECIFY** | | | | | |
|  |  |  |  |  |  |

*(Form continued on next page.)*

**Enrollee’s Last Name: Enrollee’s First Name:**

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# CLINICAL CRITERIA (*CONTINUED*)

1. The Food and Drug Administration (FDA)-approved max dosing is 20 mg TID for Revatio®/sildenafil. If the dose requested is higher, what is the clinical reason for exceeding the dose?

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1. What is the diagnosis documented in the patient’s chart that requires treatment with a phosphodiesterase type 5 (PDE-5) inhibitor?

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1. Are you currently board-certified in pulmonary or cardiovascular disease, or is there documentation in the patient’s medical record of an evaluation by a physician board-certified in pulmonary or cardiovascular disease?

Yes  No

## Questions 5-10 are for INITIAL REQUESTS ONLY. Supporting documentation is only required with initial requests.

## Please provide all of the following values from a right heart catheterization (Questions 5-9):

1. If a right heart catheterization was not done, what other documentation supports the diagnosis and explains why the patient was unable to undergo a right heart catheterization?

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1. What is the mean pulmonary artery pressure (either at rest or with exercise)? *Supporting documentation required*:

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1. What is the pulmonary artery occlusion pressure (wedge pressure)? – *Supporting documentation required*:

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1. If the wedge pressure is > 15 mmHg, what is the clinical explanation for high wedge pressure? – *Supporting documentation required*:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Form continued on next page.)*

**Enrollee’s Last Name: Enrollee’s First Name:**

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# CLINICAL CRITERIA (*CONTINUED*)

1. What is the acute pulmonary vasoreactivity (as determined during right catheterization)? – *Supporting documentation required*:

Positive responder

Negative responder

Not tested – Please provide an explanation for not performing this test and indicate if the patient has failed on a calcium channel blocker:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What New York Heart Association/ World Health Organization (NYHA/WHO) classification describes the patient’s current functional status?

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1. Before prescribing this drug, have you inquired about regular or intermittent therapy with nitrates or drugs containing nitrates within the past 180 days and completed counseling of this patient, including strong warning against the use of any drugs containing nitrates in conjunction with a PDE-5 inhibitor?

Yes  No

1. Is this patient currently using an oral erectile dysfunction medication?

Yes  No

|  |  |  |
| --- | --- | --- |
| Prescriber Signature (Required) |  | Date |
| *I attest that this is medically necessary for this patient and that all of the information on this form is accurate to the best of my knowledge. I attest that documentation of the above diagnosis and medical necessity is available for review if requested by New York Medicaid.* | | |

**Fax Number:** 1-800-268-2990

**Prior Authorization Call Line:** 1-877-309-9493

**Billing Questions:** 1-800-343-9000

For clinical questions or Clinical Drug Review Program questions, please visit <http://newyork.fhsc.com> or call 1-877-309-9493.