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Prime THERAPEUTICS™

NYRx the Medicaid Pharmacy Program

PDE-5 Inhibitors for Pulmonary Arterial Hypertension (PAH) Prior Authorization Worksheet

Fax Number: 1-800-268-2990

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: _____

Date of Birth: _____

Enrollee's Medicaid ID (2 letters, 5 numbers, 1 letter): _____

PRESCRIBER INFORMATION

Prescriber's Last Name: _____

Prescriber's First Name: _____

National Provider Identifier (NPI) Number: _____

Board Certified Specialty: _____

Prescriber's Street Address: _____

City: _____

State: _____ **Zip Code** _____

Prescriber's Phone Number: _____

Prescriber's Fax Number: _____

REQUESTED PREFERRED DRUG INFORMATION

Drug Name (sildenafil OR tadalafil):

☐ sildenafil (generic for Revatio®)

☐ tadalafil (generic for Adcirca®)

Drug Strength: _____ **Quantity:** _____ **Refills:** _____

Directions: _____

New Prescription: ☐ Yes ☐ No If **NO**, date therapy was initiated: _____

Revision Date: 04/04/2023

Enrollee's Last Name: **Enrollee's First Name:**

REQUESTED NON-PREFERRED DRUG INFORMATION

Drug Name: _____

Drug Strength: _____ **Quantity:** _____ **Refills:** _____

Directions: _____

New Prescription: ☐ Yes ☐ No If **NO**, date therapy was initiated: _____

CLINICAL CRITERIA

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?

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

3. 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 4–9 ARE FOR INITIAL REQUESTS ONLY

Please provide all the following values from a right heart catheterization (Questions 4–8). Supporting documentation is required for initial requests.

4. 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?

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

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

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

Enrollee's Last Name: **Enrollee's First Name:**

CLINICAL CRITERIA *(CONTINUED)*

8. 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:

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

10. 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

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

    ☐ Yes ☐ No

Submission of this form confirms the information is accurate and true, and that the supporting documentation is available for review upon request of said plan, the NYSDOH or CMS. The submitter understands that any person who knowingly makes or causes to be made a false record to statement that is material to a Medicaid claim may be subject to civil penalties and treble damages under both federal and NYS False Claims Acts.

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.