



Send completed form to:
Peach State Health Plan Pharmacy Department
Fax: 1-866-374-1579

Adcirca

Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copy or medication delivery; please contact Peach State Health Plan at **1-800-514-0083 option # 2.**

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

1. Which drug is being prescribed? Adcirca Other _____
2. Indicate Dose: _____ Frequency: _____
3. What is the diagnosis? Pulmonary arterial hypertension (PAH), WHO group 1
 Other _____
4. How old is the patient? _____ years
5. Has PAH been confirmed by right heart catheterization (defined as mean pulmonary pressure greater than 25 mmHg at rest or greater than 30 mmHg with exercise)? Yes No (**Fax Results**)
6. Is the patient taking a nitrate medication on a regular or intermittent basis? Yes No
7. Is the patient currently receiving Adcirca for PAH? **If Yes, no further questions.* Yes No
8. Has the patient previously received any prostanoid (e.g., Flolan, Veletri, Remodulin, Tyvaso, Ventavis), phosphodiesterase inhibitor (e.g., Revatio), or endothelin antagonist (e.g., Letairis, Tracleer) for PAH **Indicate all of the below therapies the patient has previously received, if none, mark "None of the above"**.
 Flolan Revatio Veletri Letairis Tracleer Ventavis Remodulin Tyvaso
 None of the above
9. Has the patient had an inadequate response to vasoreactivity testing? Yes No
10. Has the patient had a prior trial and failure of calcium channel blocker (CCB)? Yes No
11. Does the patient have a contraindication to CCB (e.g., right sided heart failure, left ventricular dysfunction)? Yes No

****NOTE: We can NOT make a decision without a copy of lab results - Thank You****

Information given on this form is accurate as of this date:

X _____

Prescriber or Authorized Signature

Date (mm/dd/yy)

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