



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

Flolan, Veletri

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 copay 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: _____

- Which drug is being prescribed? Flolan Veletri Other _____
- Indicate prescribed: Dose: _____ Frequency: _____
- What is the diagnosis?
 Pulmonary arterial hypertension (PAH) WHO Group 1
 Other _____
- How old is the patient? _____ years
- 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**)
- Does the patient have congestive heart failure due to severe left ventricular systolic dysfunction?
 Yes No
- Will therapy be discontinued if patient develops pulmonary edema and/or pulmonary veno-occlusive disease (PVOD) during dose initiation with epoprostenol? Yes No
- Is the patient currently receiving Flolan or Veletri for PAH? **If yes, no further questions*
 Yes No
- Has the patient previously received any prostanoid (e.g., Flolan, Veletri, Remodulin, Tyvaso, Ventavis), phosphodiesterase inhibitor (e.g., Revatio, Adcirca), 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"**.
 Adcirca Remodulin Tyvaso None of the above
 Flolan Revatio Veletri
 Letairis Tracleer Ventavis
- Has the patient had an inadequate response to vasoreactivity testing? *If yes, skip to # 13*
 Yes No

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. Centene Flolan, Veletri - MD FAX - Update 03/2011

Patient Name: _____ Patients Date of Birth: _____
Patients ID : _____

11. Has the patient had a prior trial and failure of calcium channel blocker (CCB)? *If yes, skip to # 13*
 Yes No
12. Does the patient have a contraindication to CCB (e.g., right sided heart failure, left ventricular dysfunction)? Yes No
13. Does the patient experience NYHA Class III or IV symptoms? Yes (*indicate below*) No
 NYHA Class **III** symptoms
 NYHA Class **IV** symptoms
14. Has the patient **tried and failed** a trial of Adcirca? Yes No
15. If No, is the patient contraindicated to Adcirca therapy? Yes No

****NOTE: We can NOT make a decision without a copy of the documentation - Thank You****

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

X _____
Prescriber or Authorized Signature Date (mm/dd/yy)

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. Centene Flolan, Veletri - MD FAX - Update 03/2011