



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

Remodulin

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? Remodulin Other _____
- Indicate Prescribed Dose: Tablets Injection, 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**)
- Is the patient currently receiving Remodulin for PAH? **If yes, no further questions* Yes No

Only answer below questions if the patient is currently on therapy with Remodulin

- Has the patient previously received any prostanoid (e.g. Flolan, Veletri, Tyvaso, Ventavis), phosphodiesterase inhibitor (e.g. Adcirca, 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"**
 Adcirca Letairis Tracleer Veletri None of the above
 Flolan Revatio Tyvaso Ventavis
- Has the patient had an inadequate response to vasoreactivity testing?
**If yes, Skip to # 11* Yes No
- Has the patient had a prior trial and failure of calcium channel blocker (CCB)?
**If yes, Skip to # 11* Yes No
- Does the patient have a contraindication to calcium channel blocker (CCB) (e.g. right sided heart failure, left ventricular dysfunction)? Yes No
- Does the patient experience NYHA Class II, III, or IV symptoms? Yes (**indicate below**) No
 NYHA **Class II** symptoms
 NYHA **Class III** symptoms
 NYHA **Class IV** symptoms

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

12. Has the patient **tried and failed** a trial of Adcirca? Yes No

13. 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)

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