



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

Revatio

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: _____ NPI#: _____
 Specialty: _____ NPI#: _____
 Physician Office Telephone: _____ Physician Office Fax: _____
 Physician Office Address: _____

- Which drug is being prescribed? Revatio 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

Complete the appropriate section below designated for the patients age group

SECTION A: Pediatric Patients (LESS THAN 18 years of age)

- Has PAH been confirmed by either right heart catheterization or cardiac ECHO?
 Yes No (**Fax results**)
- Is the patient currently on sildenafil (i.e. Revatio) therapy? Yes No
- If Yes, has the patient shown evidence of response to the medication? Yes No

SECTION B: Adult Patients (18 years of age or older)

- 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 taking a nitrate medication on a regular or intermittent basis? Yes No
- Is the patient currently receiving Revatio 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. 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 Veletri Letairis None of the above
 Flolan Tracleer Ventavis Tyvaso

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

12. Has the patient had an inadequate response to vasoreactivity testing?
**If Yes, skip to # 15* Yes No
13. Has the patient had a prior trial and failure of calcium channel blocker (CCB)?
**If Yes, skip to # 15* Yes No
14. Does the patient have a contraindication to calcium channel blocker (CCB) (e.g. right sided heart failure, left ventricular dysfunction)? Yes No
15. Does the patient experience NYHA Class IV symptoms? Yes No
16. Has the patient **tried and failed** a trial of Adcirca? Yes No
17. If No, is the patient contraindicated to Adcirca therapy? Yes No
18. If Revatio injection is prescribed, was the patient taking oral Revatio but is now temporarily unable to take oral medication? 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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