Anthem UM Services, Inc.

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Prostacyclins for Pulmonary Arterial Hypertension (PAH)

PreDetermination of Medical Benefits

[Flolan® (epoprostenol); Remodulin™ (treprostinil); Ventavis® (iloprost)]

Complete form in its entirety and fax to UM Call Center at (404) 848-2448

Click on grey boxes to type **Request Date:** / /

☐ Initial Authorization Request ☐ Re-Authorization Request; List Prior Auth Ref #:

☐ Medication(s) is to be dispensed, delivered, and managed by PrecisionRx Specialty Solutions (800.870.6419) ☐ Yes ☐ No

1. PATIENT INFORMATION

Patient Last Name	Patient First Name	Patient ID Number	Patient DOB / /
Address	City	State / Zip Code /	Contact Phone Number ( ) -
Date of Diagnosis / /	Primary Diagnosis	ICD-9 Code(s)	Patient's Current Weight

2. PHYSICIAN INFORMATION

Physician Last Name	Physician First Name	Physician DEA or NPI Number	Physician Tax ID
Address	City	State	Zip Code
Office Phone Number ( ) -	Office Fax Number ( ) -	Office Contact Name	Physician Specialty

3. MEDICATION INFORMATION – This section serves as the active prescription – signature required.

Drug Name	HCPCS or CPT Code(s)	Strength / Dose
☐ **Flolan** ☐ **Remodulin** ☐ **Ventavis**	☐ **J1325** ☐ **J3285** ☐ **Q4080**	

Direction for Use (SIG)

Date patient is scheduled to be treated (need by date) / /	Service From Date / /	Service Thru Date / /	Number of Refills

Place of Service

☐ MD Office ☐ Pt's Home ☐ Other: (please specify)

Prescriber Signature	Date / /

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4. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: **To avoid delays**, please complete this form in its entirety. Incomplete forms that are missing pertinent information will be pended. If indicated, please provide **ALL** supporting lab results, progress notes, etc.

(1) Pulmonary Arterial Hypertension

☐ Yes ☐ No Is pt diagnosed with pulmonary arterial hypertension documented by right heart catheterization?

☐ Yes ☐ No Does pt have idiopathic (primary) pulmonary hypertension or pulmonary hypertension secondary to connective tissue disorders or congenital heart defects with **NYHA Class III or IV symptoms?**

☐ Yes ☐ No Did pt demonstrate an unfavorable acute hemodynamic response to vasodilators administered at cardiac catheterization?

(2) Other Use(s) (This will not be reviewed unless all supporting evidence/documentation, labs, etc., are attached.)

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5. PHYSICIAN SIGNATURE

	/ /
Prescriber Signature	**Date**

Prior Authorization is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

IMPORTANT WARNING: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is **STRICTLY PROHIBITED**. If you have received this message by error, please notify us immediately at 800-722-6614 and destroy the related message or return the document to us at 3350 Peachtree Rd. NE, Atlanta, GA 30326. You, the recipient, are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure without appropriate patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in Federal and State law.

Medical Policy Reference can be found at: www.bcbsga.com

Anthem UM Services, Inc. an independent company and is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan.