Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
UPTRAVI (Selexipag), TYVASO (Treprostinil), ORENITRAM (Treprostinil/Diolamine).
Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage **UPTRAVI (Selexipag), TYVASO (Treprostinil), ORENITRAM (Treprostinil/Diolamine).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete. KP-MAS Formulary can be found at: http://www.providers.kaiserpermanente.org/mas/formulary.html**

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Is the prescriber a Pulmonologist or Cardiologist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, State date: _____
2. Indicate the Member's diagnosis for the requested medication: _____
3. Does the member have a diagnosis of pulmonary arterial hypertension World Health Organization [WHO] Group I? **OR**
   □ No □ Yes
4. Does the member have a diagnosed with WHO/New York Heart Association Functional Class II, III or IV symptoms? **AND**
   □ No □ Yes
5. Is member currently receiving a prostanoid/prostacyclin analogue (e.g. treprostinil (Orenitram®, Tyvaso®, Remodulin®)? **AND**
   □ No □ Yes
6. Is there documentation treatment failure, intolerance, or contraindication to at least two of the following:
   a. One phosphodiesterase type (PDE-5) inhibitor (e.g. sildenafil (Revatio®), tadalafil (Adcirca®) **OR**
   b. One endothelin receptor antagonist (ERA) (e.g. ambrisentan (Letairis®), or bosentan (Tracleer®) **OR** macitentan (Opsumit) **OR**
   c. A soluble guanylate cyclase stimulator Riociguat (Adempas®)

   □ No □ Yes

For Continuation of Therapy, Please Respond to Additional Questions Below:

1. Is there documentation the member is experiencing clinical benefit from therapy as evidenced by disease stability or disease improvement? **AND**
   □ No □ Yes
2. Does member continue to meet initial review criteria?
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information – Please submit chart notes/medical records for the patient that are applicable to this request. Provide any additional supporting information that should be taken into consideration:

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**