

**Orenitram® Prior Authorization Request Form (Page 1 of 2)**

<b>Member Information (required)</b>			<b>Provider Information (required)</b>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
<b>Medication Information (required)</b>					
Medication Name:			Strength:	Dosage Form:	
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
<b>Clinical Information (required)</b>					
<b>Select the diagnosis below:</b>					
<input type="checkbox"/> Pulmonary arterial hypertension (PAH)					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
<b>Clinical Information:</b>					
Does the patient have pulmonary arterial hypertension (PAH) that is symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Was the diagnosis of PAH confirmed by right heart catheterization? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the patient currently on any therapy for the diagnosis of PAH? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the requested medication prescribed by or in consultation with a pulmonologist or cardiologist? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Reauthorization:</b>					
<b>If this is a reauthorization request, answer the following question:</b>					
Is there documentation the patient has had a positive clinical response to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Quantity Limit Requests:</b>					
What is the quantity requested per DAY? _____					
<b>What is the reason for exceeding the plan limitations?</b>					
<input type="checkbox"/> Titration or loading dose purposes					
<input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)					
<input type="checkbox"/> Requested strength/dose is not commercially available					
<input type="checkbox"/> Other: _____					



1230 US Highway 11  
Gouverneur, NY 13642  
Phone: 1-877-635-9545

Prior Authorization Fax: 1-844-712-8129

## Orenitram® Prior Authorization Request Form (Page 2 of 2)

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.

**Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.**

**Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.**

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): \_\_\_\_\_ Date: \_\_\_\_\_

### PROACT INTERNAL USE ONLY:

#### Clinical Review Decision

Approved, through

Denied (documentation attached, if necessary)

#### Tracking:

1<sup>st</sup> Attempt

2<sup>nd</sup> Attempt

Letter Mailed:

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of ProAct. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Orenitram\_Jan\_2018