AmeriHealth Caritas™
New Hampshire

# Pulmonary Arterial Hypertension

## Prior Authorization Drug Approval Form

Date of medication request: (MM/DD/YYYY): ____ / ____ / ______

| Patient information and medication requested | |
|---|---|
| Patient's name: | Medicaid number: |
| Date of birth: | Gender: |
| Drug name: | Strength: |
| Dosing directions: | Length of therapy: |

| Prescriber information | |
|---|---|
| Prescriber last name: | Prescriber first name: |
| Prescriber address: | Prescriber representative: |
| NPI number: | Specialty: |
| Phone #: | Fax #: |

| Clinical history |
|---|
| 1. For what condition is this medication being prescribed? |
| 2. Is the prescriber a cardiologist or pulmonologist, experienced in the diagnosis and treatment of pulmonary hypertension, or has one of these specialists been consulted in this case? ☐ Yes ☐ No |
| 3. Will the patient be on concurrent organic nitrates, guanylate cyclase stimulators, or other PAH medications? ☐ Yes ☐ No |
| 4. Is the request for sildenafil? ☐ Yes ☐ No<br>If yes, will there be concomitant use with HIV protease inhibitors or elvitegravir/cobicistat/emtricitabine? ☐ Yes ☐ No |
| Provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet. |

Signature of prescriber:________________________________ Date: ______________
(prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.