PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 1/31/2025
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **NPI#:** **Patient Phone:** _____ **Physician Name:**
Specialty:
Physician Office Telephone:
Physician Office Address: _____

Drug Name (specify drug) _____

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please check the appropriate answer for each applicable question.

1. What is the diagnosis?
   - Pulmonary arterial hypertension (PAH) (If checked, go to 3) ☐
   - Secondary Raynaud's phenomenon (If checked, go to 4) ☐
   - Erectile dysfunction (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

     _____

2. You have indicated branded or generic sildenafil is being requested for a diagnosis of erectile dysfunction. Based on your response, this request is not likely to be approved for coverage as it is not being prescribed for a diagnosis that is covered under the patient's current plan approved criteria. Current plan approved criteria will only approve this drug and strength for pulmonary arterial hypertension (PAH) and secondary Raynaud's phenomenon. If you would like to proceed, select Yes below. Submission of this prior authorization request will require additional clinical review. If you would like not to proceed, please delete this request.
   - Yes (If checked, no further questions) ☐
   - No - Please cancel request. (If checked, no further questions) ☐

3. Is the requested drug prescribed by or in consultation with a pulmonologist or cardiologist? **Y** ☐ **N** ☐

4. Is the patient currently receiving treatment with the requested drug? **Y** ☐ **N** ☐

5. Is the patient currently receiving the requested drug through a paid pharmacy or medical benefit?
   - Yes (If checked, go to 6) ☐
   - No (If checked, go to 7) ☐
   - Unknown (If checked, go to 7) ☐

6. Is the patient experiencing benefit from therapy with the requested drug as evidenced by disease stability or disease improvement? **Y** ☐ **N** ☐

7. What is the diagnosis?
   - Pulmonary arterial hypertension (PAH) (If checked, go to 8) ☐

Secondary Raynaud's phenomenon (If checked, go to 17) ☐

8. What is the World Health Organization (WHO) classification of pulmonary hypertension?

WHO Group 1 (Pulmonary arterial hypertension) (If checked, go to 9) ☐

WHO Group 2 (Pulmonary hypertension due to left heart disease) (If checked, no further questions) ☐

WHO Group 3 (Pulmonary hypertension due to lung disease and/or hypoxia) (If checked, no further questions) ☐

WHO Group 4 (Pulmonary hypertension due to pulmonary artery obstruction) (If checked, no further questions) ☐

WHO Group 5 (Pulmonary hypertension with unclear and/or multifactorial mechanisms) (If checked, no further questions) ☐

9. Has the diagnosis been confirmed by pretreatment right heart catheterization? **Y** ☐ **N** ☐

10. What is the pretreatment mean pulmonary arterial pressure (mPAP)?

Greater than 20 mmHg (If checked, go to 11) ☐

Less than or equal to 20 mmHg (If checked, no further questions) ☐

11. What is the pretreatment pulmonary capillary wedge pressure (PCWP)?

Less than or equal to 15 mmHg (If checked, go to 12) ☐

Greater than 15 mmHg (If checked, no further questions) ☐

12. Is the patient less than 18 years of age? **Y** ☐ **N** ☐

13. What is the pretreatment pulmonary vascular resistance (PVR)?

Greater than or equal to 3 Wood units (If checked, no further questions) ☐

Less than 3 Wood units (If checked, no further questions) ☐

14. What is the pretreatment pulmonary vascular resistance index (PVRI)? (Note: m2 represents unit of body surface area, meters squared.)

Greater than or equal to 3 Wood units x m2 (If checked, no further questions) ☐

Less than 3 Wood units x m2 (If checked, no further questions) ☐

15. Is the patient an infant less than one year of age? **Y** ☐ **N** ☐

16. Has Doppler echocardiogram been performed to confirm the diagnosis? **Y** ☐ **N** ☐

17. Has the patient had an inadequate response to one of the following drugs: A) Calcium channel blockers, B) Angiotensin II receptor blockers, C) Selective serotonin reuptake inhibitors, D) Alpha blockers, E) Angiotensin-converting enzyme inhibitors, or F) Topical nitrates?

Yes - Calcium channel blockers (If checked, no further questions) ☐

Yes - Angiotensin II receptor blockers (If checked, no further questions) ☐

Yes - Selective serotonin reuptake inhibitors (If checked, no further questions) ☐

Yes - Alpha blockers (If checked, no further questions) ☐

Yes - Angiotensin-converting enzyme inhibitors (If checked, no further questions) ☐

Yes - Topical nitrates (If checked, no further questions) ☐

No - Other, please specify. (If checked, no further questions) ☐

_____

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date

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