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:** 10/9/2026
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
Physician Office Address: _____ **Physician Office Telephone:**

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 hypertension (PH) (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

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

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

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

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

6. What is the World Health Organization (WHO) classification of pulmonary hypertension?
   - WHO Group 1 (Pulmonary arterial hypertension) (If checked, go to 8) ☐
   - WHO Group 2 (Pulmonary hypertension associated with left heart disease) (If checked, no further questions) ☐
   - WHO Group 3 (Pulmonary hypertension associated with lung diseases and/or hypoxia) (If checked, go to 7) ☐
   - WHO Group 4 (Pulmonary hypertension associated with pulmonary artery obstructions) (If checked, no further questions) ☐
   - WHO Group 5 (Pulmonary hypertension with unclear and/or multifactorial mechanisms) (If checked, no further questions) ☐

7. Does the patient have pulmonary hypertension associated with interstitial lung disease? **Y** ☐ **N** ☐

8. Has pulmonary hypertension been confirmed by pretreatment right heart catheterization? **Y** ☐ **N** ☐

9. What is the pretreatment mean pulmonary arterial pressure (mPAP)?
   - Greater than 20 mmHg (If checked, go to 10) ☐
   - Less than or equal to 20 mmHg (If checked, no further questions) ☐

10. What is the pretreatment pulmonary capillary wedge pressure (PCWP)?
   - Less than or equal to 15 mmHg (If checked, go to 11) ☐
   - Greater than 15 mmHg (If checked, no further questions) ☐

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

12. What is the pretreatment pulmonary vascular resistance (PVR)?
   - Greater than 2 Wood units (If checked, no further questions) ☐
   - Less than or equal to 2 Wood units (If checked, no further questions) ☐

13. What is the pretreatment pulmonary vascular resistance (PVR)?
   - Greater than 2 Wood units (If checked, no further questions) ☐
   - Less than or equal to 2 Wood units (If checked, go to 14) ☐

14. What is the pretreatment pulmonary vascular resistance index (PVRI)? (Note: m2 represents unit of body surface area, meters squared.)
   - Greater than 3 Wood units x m2 (If checked, no further questions) ☐
   - Less than or equal to 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** ☐

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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