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2020 sildenafil 20 mg (generic Revatio® only) Tablet
Prior Authorization Request

(You must complete all pages.)

Fax completed form to: 1-800-408-2386 **For urgent requests, please call: 1-800-414-2386**

Coverage Criteria:

- Medication is covered on plan when prescribed for:
  - Pulmonary arterial hypertension (PAH) (WHO Group I) in adults to improve exercise ability and delay clinical worsening, when PAH has been confirmed by right heart catheterization
    AND
    For NEW starts, the patient must have ALL the following:
    1. Pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg
    2. Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg
    3. Pretreatment pulmonary vascular resistance is greater than 3 Wood units

Authorization duration: Through end of plan contract year

Patient information		**Prescriber information**	
Patient name		Today's date	Physician specialty
Patient insurance ID number		Physician name	NPI/DEA number
Patient address, city, state, ZIP		Physician address, city, state, ZIP	
Patient home telephone number		M.D. office telephone number	
Gender ☐ Male ☐ Female	Patient date of birth	M.D. office fax number	

Diagnosis and medical information			
Medication requested ☐ sildenafil (generic Revatio) 20mg tablet		**Frequency**	
New prescription OR date therapy initiated	**Quantity**	**Day supply**	**Expected length of therapy**

Diagnosis (*Please check all boxes that apply and include all office notes supporting diagnosis.)*

☐ Pulmonary arterial hypertension (WHO Group I) in adults to improve exercise ability and delay clinical worsening

☐ Other (ICD-10 codes): _____

Please check all boxes that apply:

1. ☐ **Patient is stable on current drug(s) and/or current quantity, and therapy change would likely result in adverse clinical outcomes.**
2. ☐ **All covered Part D drugs on any tier of the plan's formulary would not be as effective for the enrollee as the requested formulary drug and/or would likely have adverse effects for the enrollee.**
3. ☐ Yes ☐ No Will sildenafil 20mg tablet ONLY be used for a diagnosis of erectile dysfunction (ED) in a patient that does NOT have a diagnosis of pulmonary arterial hypertension (PAH) WHO Group I?

(continued on page 2)

Please check all boxes that apply *(continued)*:

4. **For the diagnosis of WHO Group I pulmonary arterial hypertension (PAH): Please complete this section.**

☐ Yes ☐ No Was the diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization?

For NEW STARTS only:

☐ Yes ☐ No Was the pretreatment mean pulmonary arterial pressure greater than or equal to 25 mmHg?

☐ Yes ☐ No Was the pretreatment pulmonary capillary wedge pressure less than or equal to 15 mmHg?

☐ Yes ☐ No Was the pretreatment pulmonary vascular resistance greater than 3 Wood units?

Please complete this section below only if your patient does not meet the standard requirements listed above.

Please explain why your patient should be considered for exception although not meeting the plan's suggested PA criteria. Statement should include specifically which requirement is not met and why patient should be exempt from meeting this requirement. (Please note any information that is incomplete or illegible will delay the review process.)

_____

_____

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_____

5. ☐ Yes ☐ No **The quantity limit for sildenafil 20mg tablet is 90 tablets per 30 days. Does patient require higher dosage (quantity limit exception)?**

►If yes, indicate quantity requested: _____ per 30 days OR quantity _____ per day

☐ The number of doses available under the dose restriction for the prescription drug has been ineffective in the treatment of the enrollee's disease or medical condition.

☐ The number of doses available under the dose restriction for the prescription drug, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

6. ☐ **Please list all medications the patient has tried specific to the diagnosis and specify below.**

CURRENT/PAST MEDICATIONS USED	DATES OF TREATMENT	THERAPEUTIC OUTCOME

7. ☐ **Other supporting information**

*NOTE: All exception requests require prescriber supporting statements. Additionally, requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Please attach supporting information, as necessary, for your request.

_____

_____

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_____

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 documentation supporting this information is available for review if requested by the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. See, e.g., 31 U.S.C. §§ 3729-3733. By signing this form, I represent that I have obtained patient consent as required under applicable state and federal law, including but not limited to the Health Information Portability and Accountability Act (HIPAA) and state re-disclosure laws related to HIV/AIDS.

Prescriber signature	**Date**