FUTURE SCRIPTS Secure

Please complete ALL information below and fax your request to 1-888-671-5285

Uptravi® Coverage Determination Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:	Office Contact:	
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type of Coverage Determination Requested:

❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

Select the diagnosis below:

❑ Pulmonary arterial hypertension (PAH)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's Specialty:

Is Uptravi prescribed by a cardiologist or pulmonologist? ❑ **Yes** ❑ **No**

Clinical Information:

Is there documentation the patient has PAH WHO Group I with New York Heart Association (NYHA) Functional Class II- IV? ❑ **Yes** ❑ **No**

Select if there is documentation the patient's diagnosis was confirmed by the following:

- ❑ Catheterization (right-heart or Swan-Ganz)
- ❑ Echocardiography

Select if there is documentation the patient has the following:

- ❑ Mean pulmonary artery pressure greater than or equal to 25 mm Hg at rest
- ❑ Mean pulmonary artery pressure greater than 30 mm Hg with exertion

Select if there is documentation the patient has had an inadequate response or inability to tolerate the following:

- ❑ Endothelin receptor antagonist (Tracleer if naïve to the class)
- ❑ Phosphodiesterase inhibitor (sildenafil if naïve to the class)
- ❑ Riociguat (Adempas)

Is there documentation the patient will not be taking Uptravi in combination with a prostanoid/prostacyclin analogue (e.g., epoprostenol, iloprost, treprostinil)? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation of patient's stabilization or improvement as evaluated by a cardiologist or pulmonologist? ❑ **Yes** ❑ **No**

Is there documentation the patient will not be taking Uptravi in combination with a prostanoid/prostacyclin analogue (e.g., epoprostenol, iloprost, treprostinil)? ❑ **Yes** ❑ **No**

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.

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