



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

### Revatio® (sildenafil) Prior Authorization Request Form

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#### Member Information (required) Provider Information (required)

Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

#### Medication Information (required)

Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if generic substitution is acceptable		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

#### Clinical Information (required)

**Select the diagnosis below:**

Pulmonary arterial hypertension (PAH)

Other diagnosis: \_\_\_\_\_ ICD-10 Code(s): \_\_\_\_\_

**Clinical Information:**

Does the patient have pulmonary arterial hypertension (PAH) that is symptomatic?  Yes  No

Was the diagnosis of PAH confirmed by right heart catheterization?  Yes  No

Is the patient currently on any therapy for the diagnosis of PAH?  Yes  No

Is the requested medication prescribed by or in consultation with a pulmonologist or cardiologist?  Yes  No

**For Revatio or sildenafil injection, also answer the following:**

Is the patient unable to take oral medications?  Yes  No

**For Revatio oral suspension, also answer the following:**

Does the patient have history of intolerance to sildenafil (generic Revatio) tablets?  Yes  No

Is the patient unable to ingest a solid dosage form (e.g., an oral tablet or capsule) due to age, oral-motor difficulties, or dysphagia?  Yes  No

**Reauthorization:**

**If this is a reauthorization request, answer the following question:**

Is there documentation the patient has had a positive clinical response to therapy?  Yes  No

**Quantity Limit Requests:**

What is the quantity requested per DAY? \_\_\_\_\_

**What is the reason for exceeding the plan limitations?**

Titration or loading dose purposes

Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

Requested strength/dose is not commercially available

Other: \_\_\_\_\_

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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