Revatio (Sildenafil)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION		
LAST NAME:	**FIRST NAME:**	
PHONE NUMBER:	**DATE OF BIRTH:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
PATIENT INSURANCE ID NUMBER:		

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** ______ **WEIGHT (LB/KG):** ______ **ALLERGIES:** ______________________

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): ________________________________
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: ________________________________

PRESCRIBER INFORMATION		
LAST NAME:	**FIRST NAME:**	
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**	
NPI NUMBER:	**DEA NUMBER:**	
PHONE NUMBER:	**FAX NUMBER:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY**	☐ **RENEWAL**	**IF RENEWAL:** DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

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MEMBER'S LAST NAME: ___________________________ **MEMBER'S FIRST NAME:** ___________________________

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?	☐ YES (if yes, complete below)	☐ NO
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	**DURATION OF THERAPY** (SPECIFY DATES):	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
□ Pulmonary arterial hypertension (PAH) □ Raynaud's phenomenon □ Diagnosis______________ICD-10 Code(s):____________	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

For pulmonary arterial hypertension, answer the following:

Does the patient have a diagnosis of Group 1 pulmonary arterial hypertension (PAH)? □ Yes □ No

Select if the diagnosis of Group 1 pulmonary arterial hypertension (PAH) is caused by one of the following etiologies:*

□ Chronic hemolytic anemia
□ Congenital heart disease
□ Drugs and toxins induced
□ HIV infection
□ Idiopathic/primary PAH
□ Portal hypertension
□ Schistosomiasis
□ Tissue disease (e.g., lupus/SLE, RA scleroderma, systemic sclerosis, CREST syndrome, polymyositis, polyarteritis nodosa, mixed connective tissue disease)

Please provide documentation.

Does the patient have WHO functional class II, III, or IV?* □ Yes □ No

Please provide documentation.

Is patient's diagnosis confirmed by cardiac catheterization? □ Yes □ No

Select if the one of the follow ing sets of measurements (at rest) w ere measured by cardiac catheterization to confirm PAH:*

□ MPAP 25 mmHg or greater + PCWP less than 19 mmHg / LVEDP not reported
□ MPAP 25 mmHg or greater + LVEDP less than 19 mmHg / PCWP not reported
□ MPAP 25 mmHg or greater + PCWP less than 19 mmHg + LVEDP less than 19 mm/Hg

A copy of the cardiac catheterization report must be included.

Select the prescribing physician's specialty:

□ Cardiology
□ Nephrology
□ Pulmonology

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□ **Rheumatology**
For Raynaud's phenomenon, answer the following:

Is the prescribing physician a rheumatologist? □ **Yes** □ **No**

Is the patient's Raynaud's phenomenon secondary to systemic sclerosis/scleroderma?* □ **Yes** □ **No**
Please provide documentation.

Has the patient received prior treatment w ith, and is intolerant of or resistant to, at least one calcium channel blocker?* □ **Yes** □ **No**
Please provide documentation.

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

____

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Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: ________________________________ **Date:** ________________

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FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.
4801 E. Washington Street, Phoenix, AZ 85034
Phone: 877-228-7909

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