



Winrevair (sotatercept-csrk)
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](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:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.





Winrevair (sotatercept-csrk)
Prior Authorization Request Form
 Caterpillar Prescription Drug Benefit
 Phone: 877-228-7909 Fax: 800-424-7640



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:**

<input type="checkbox"/> Pulmonary arterial hypertension (PAH) <input type="checkbox"/> Other diagnosis: _____ ICD-10 _____	
--	--

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

Clinical Information:
 Is the requested medication prescribed by a pulmonologist, cardiologist, nephrologist, or rheumatologist? Yes No

Does the patient have a diagnosis of pulmonary arterial hypertension (WHO Group 1)? Yes No
Please submit documentation.

Select if the patient has any of the following causes for pulmonary arterial hypertension (PAH):
Please submit documentation.

- Idiopathic/Primary PAH
- Drugs and toxin induced
- Connective tissue disease (e.g., Lupus/SLE, RA scleroderma, systemic sclerosis, CREST syndrome, polymyositis, polyarteritis nodosa, mixed connective tissue disease)
- HIV infection
- Portal hypertension
- Congenital heart disease(e.g. atrial septal defect)
- Associated with surgical repair of a congenital systemic-to-pulmonary shunt of at least 1 year in duration(e.g. ventricular septal defect, patent ductus arteriosus)
- Schistosomiasis
- Chronic hemolytic anemia

Does the patient experience WHO Functional Class II through IV symptoms? Yes No
Please submit documentation.

Select if the patient's cardiac catheterization report meets any of the following:*

Does patient have, (at rest), measured by cardiac catheterization a mean pulmonary artery pressure(mPAP of 20mmHg or greater via right heart cath to confirm PAH? Yes No **Please provide documentation.*

Does patient have, (at rest), measured by cardiac catheterization a pulmonary capillary wedge pressure(PCWP) 15mmHg or less via right heart cath to confirm PAH? Yes No **Please provide documentation.*





Winrevair (sotatercept-csrk)
Prior Authorization Request Form
 Caterpillar Prescription Drug Benefit
 Phone: 877-228-7909 Fax: 800-424-7640



Does patient have, (at rest), measured by cardiac catheterization a pulmonary vascular resistance(PVR) value equaling 3 wood units or greater via right heart cath to confirm PAH? Yes No **Please provide documentation.*

If patient has idiopathic PAH, hereditaryPAH(excludes congenital heart disease like atrial=septal defect) or drug/toxin induced PAH, did patient have had an acute vasoreactivity test? Yes No **Please provide documentation.*

Has patient had an inadequate response or intolerance to at least 2 of the following?: Yes No **Please provide documentation.*

- a PDE5 inhibitor (i.e., generic Revatio, Adcirca);
- an ERA(Letairis (ambrisentan), Tracleer (bosentan), Opsumit (macitentan)
- Adempas(riociguat)

Has patient been previously treated with a 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?

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:** _____

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program

Attn: CP – 4201

P.O. Box 64811

St. Paul, MN 55164-0811

