Amerigroup
An Anthem Company

https://providers.amerigroup.com

Pulmonary Hypertension Agents
Prior Authorization of Benefits Form

Contains confidential patient information
Complete form in its entirety and fax to the Prior Authorization of Benefits Center at 1-844-474-3341.

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician:_____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #:_____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
			Specify:

7. Diagnosis:

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Injectable agents

□ Yes □ No Does the client have a diagnosis of pulmonary arterial hypertension (PAH) in the last 730 days?
□ Yes □ No Has the diagnosis been confirmed by or does the client have a contraindication to right heart catheterization?
□ Yes □ No Has the client tried other available PAH therapies in the last 180 days?
□ Yes □ No Does the client have a contraindication to other available PAH therapies

Oral/inhaled agents

□ Yes □ No Does the client have a diagnosis of PAH in the last 730 days?
□ Yes □ No Does the client have a diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH) in the last 730 days?
□ Yes □ No Has the diagnosis been confirmed by or does the client have a contraindication to right heart catheterization?
□ Yes □ No Has the diagnosis been confirmed by or does the client have a contraindication to pulmonary angiogram?

Amerigroup members in the Medicaid Rural Service Area and the STAR Kids program are served by Amerigroup Insurance Company; all other Amerigroup members in Texas are served by Amerigroup Texas, Inc.

Non-preferred agents

□ Yes □ No Patient has failed a 30-day treatment trial with at least one preferred agent(s) within the past 180 days.
□ Yes □ No Patient has a documented allergy or contraindication to preferred agents in this class.
□ Yes □ No Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.

For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at **http://www.txvendordrug.com/formulary/formulary-search.asp**.

9. Physician signature

_____ _____

Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.
Note: Payment is subject to member eligibility. Authorization does not guarantee payment.