Flolan, Veltri
(epoprostenol)

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462 (800.88.CIGNA)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication Requested:
☐ epoprostenol
☐ Flolan
☐ Veletri
☐ **Other (please specify):** ICD10:

Dose and Quantity: Frequency of administration: Duration of therapy: J-Code (if injectable):

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication (if injectable):
Facility Name: State: Tax ID#:

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:
☐ Pulmonary arterial hypertension (PAH) World Health Organization (WHO) Group 1
☐ Chronic thromboembolic pulmonary hypertension (CTEPH)
☐ Chronic obstructive pulmonary disease (COPD) in a patient without pulmonary arterial hypertension (PAH) World Health Organization (WHO) Group 1
☐ Other indications or diagnosis

Clinical Information:

Will the patient be taking the requested medication with parenteral treprostinil products, oral prostacyclin products, or inhaled prostacyclin agents used for pulmonary hypertension? Please Note: Examples of medications include Tyvaso (treprostinil inhalation solution), Tyvaso DPI (treprostinil oral inhalation powder), Ventavis (iloprost inhalation solution), and treprostinil injection (Remodulin, generic). ☐ Yes ☐ No

For Pulmonary arterial hypertension (PAH) World Health Organization (WHO) Group 1

Is the patient currently receiving epoprostenol? ☐ Yes ☐ No

Does the patient have WHO Group 1 PAH? ☐ Yes ☐ No

Is the medication being prescribed by, or in consultation with, a cardiologist or a pulmonologist? ☐ Yes ☐ No

(if currently receiving) Has the patient had a right heart catheterization? Note: This refers to prior to starting therapy with a medication for WHO Group 1 PAH. ☐ Yes ☐ No

(if currently receiving) Did the results of the right heart catheterization confirm the diagnosis of WHO Group 1 PAH? ☐ Yes ☐ No

(if not currently receiving) Is documentation being provided to confirm that the patient has had a right heart catheterization? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Documentation may include, but is not limited to, chart notes and catheterization laboratory reports. All documentation must include patient-specific identifying information. For a patient case in which the documentation requirement of the right heart catheterization upon prior authorization coverage review for a different medication indicated for WHO Group 1 PAH has been previously provided, the documentation requirement in this Pulmonary Arterial Hypertension - Epoprostenol injection Prior Authorization Policy is considered to be met. ☐ Yes ☐ No

(if not currently receiving) Did the results of the right heart catheterization confirm the diagnosis of WHO Group 1 PAH? ☐ Yes ☐ No

(if not currently receiving) Is the patient in Class III or IV of the WHO classification of functional status? ☐ Yes ☐ No

(if no) Is the patient in Class II of the WHO classification of functional status? ☐ Yes ☐ No

Has the patient tried or is the patient currently receiving one oral agent for PAH? Note: Examples of oral agents for PAH include bosentan, ambrisentan, Opsumit (macitentan tablets), Opsynvi (macitentan/tadalafil tablets), sildenafil, tadalafil, Adempas (riociguat tablets), Alyq (tadalafil tablets), and Tadliq (tadalafil oral suspension). ☐ Yes ☐ No

(if no) Has the patient tried one inhaled or parenteral prostacyclin product for PAH? Note: Examples of inhaled and parenteral prostacyclin products for PAH include Tyvaso (treprostinil inhalation solution), Tyvaso DPI (treprostinil oral inhalation powder), Ventavis (iloprost inhalation solution), Yutrepia (treprostinil oral inhalation powder), treprostinil injection, and epoprostenol injection. ☐ Yes ☐ No

Does the patient have idiopathic PAH? ☐ Yes ☐ No

(if yes) Has the patient tried one calcium channel blocker (CCB) therapy? Note: Examples of CCBs include amlodipine, nifedipine extended-release tablets. ☐ Yes ☐ No

(if no) Is the patient unable to take calcium channel blocker therapy? Note: Examples of reasons a patient cannot take calcium channel blocker therapy include right heart failure or decreased cardiac output. ☐ Yes ☐ No

(if no) Did the patient have vasodilator testing? ☐ Yes ☐ No

(if no) Is the patient unable to undergo a vasodilator test according to the prescriber? ☐ Yes ☐ No

(if yes) Has the patient had an acute response to vasodilator testing that occurred during the right heart catheterization according to the prescriber? Please Note: An example of a response can be defined as a decrease in mPAP of at least 10 mm Hg to an absolute mPAP of less than 40 mm Hg without a decrease in cardiac output. ☐ Yes ☐ No

For Chronic thromboembolic pulmonary hypertension (CTEPH)

Is the medication being prescribed by, or in consultation with, a cardiologist or a pulmonologist? ☐ Yes ☐ No

Additional pertinent information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer 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:_____ **Date:**_____

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

v120125

 Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005