Remodulin
(*Treprostinil*)

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:
☐ Remodulin
☐ Treprostinil
☐ **Other** 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:
☐ Chronic obstructive pulmonary disease (COPD) in a patient without PAH (WHO Group 1)
☐ Chronic thromboembolic pulmonary hypertension (CTEPH)
☐ Pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1)
☐ Other

Clinical Information:

Will the patient be taking the requested medication with parenteral epoprostenol products, oral prostacyclin products, or inhaled prostacyclin agents used for pulmonary hypertension? Please Note: Examples of medications include Orenitram (treprostinil extended-release tablets), Uptravi (selexipag tablets and intravenous infusion), Tyvaso (treprostinil inhalation solution), Tyvaso DPI (treprostinil oral inhalation powder), Ventavis (iloprost inhalation solution), and epoprostenol injection (Flolan, Veletri, generic).
☐ Yes ☐ No

If CTEPH:

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

If PAH:

Does the patient have a diagnosis of World Health Organization (WHO) Group 1 pulmonary arterial hypertension (PAH)?
☐ Yes ☐ No

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

Is the patient currently receiving the requested medication? ☐ Yes ☐ No

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

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

(if Initial therapy) Is documentation being provided to show 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. All documentation must include patient-specific identifying information. Documentation may include, but is not limited to, chart notes and catheterization laboratory reports. 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 PAH - Treprostinil Injection (Remodulin) PA Policy is considered to be met. ☐ Yes ☐ No

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

(if Initial therapy) Is the patient in Functional Class III or IV? ☐ Yes ☐ No

(if no) Is the patient in Functional Class II? ☐ Yes ☐ No

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

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

(if Initial therapy) Does the patient have idiopathic PAH? ☐ Yes ☐ No

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

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

(if yes vasodilator testing) According to the prescriber, did the patient have an acute response to vasodilator testing? ☐ Yes ☐ No

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

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

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

If PAH and requesting Remodulin (brand only):

Has the patient already been started on Remodulin or treprostinil therapy? ☐ Yes ☐ No

(if no) Has the patient tried generic treprostinil? ☐ Yes ☐ No

(if no) Will the patient be using the requested medication for continuous subcutaneous infusion? ☐ Yes ☐ No

(if yes) Is the patient unable to take generic treprostinil because appropriate durable medical equipment is not available such as the patient does not have or cannot obtain a compatible pump that allows generic treprostinil to be administered? ☐ 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:**_____

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