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

PAH Therapy

(Adcirca, Adempas, bosentan, Flolan, Letairis, Opsumit, Orenitram, Remodulin, Revatio, Tracleer, Tyvaso, Uptravi, Veletri, Ventavis)

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)

Oral Medication Requested:
☐ Adcirca ☐ Adempas ☐ Alyq ☐ ambrisentan ☐ bosentan
☐ Letairis ☐ Opsumit ☐ Orenitram ☐ Revatio tablets ☐ Revatio suspension
☐ sildenafil 20mg tablet ☐ sildenafil oral suspension ☐ tadalafil ☐ Tracleer
☐ Uptravi

Inhalation Medication Requested:
☐ Tyvaso ☐ Ventavis

Injectable Medication Requested:
☐ epoprostenol ☐ Flolan ☐ Remodulin ☐ Revatio ☐ sildenafil
☐ 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 (1640 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 this drug being prescribed by, or in coordination with, a pulmonologist, cardiologist, or rheumatologist? ☐ Yes ☐ No

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 (please specify):
☐ Pulmonary Arterial Hypertension (PAH)
☐ Pulmonary Hypertension (PH) ☐ Other (please specify):

Clinical Information:
Is this for new therapy or continued therapy? ☐ New therapy ☐ Continued therapy
(if continued therapy) What was the previous dosage?

Was the diagnosis of PH documented by right heart catheterization or echocardiogram? ☐ Yes ☐ No

Which of the following applies to your patient's diagnosis?

- ☐ condition is proven idiopathic PAH (IPAH) or heritable PAH (HPAH) (WHO group 1)
- ☐ condition has unclear multifactorial mechanisms (WHO group 5)
- ☐ condition is drug/toxin induced or associated with any of the following: connective tissue disease, HIV infection, portal hypertension, congenital heart diseases, or schistosomiasis (WHO group 1)
- ☐ condition is associated with left heart disease (WHO group 2)
- ☐ condition is associated with lung diseases and/or hypoxia (WHO group 3)
- ☐ chronic thromboembolic pulmonary hypertension (CTEPH) (WHO group 4)
- ☐ condition has unclear multifactorial mechanisms (WHO group 5)
- ☐ condition is associated with any of the following: hematological disorder (for example: myeloproliferative disorder), systemic disorder (sarcoidosis, pulmonary histiocytosis), metabolic disorder (Gaucher, thyroid), chronic renal failure (CRF), segmental PH (WHO group 5)
- ☐ other/unknown

(if other/unknown) Has your patient been classified in either of the following functional assessments of PAH: World Health Organization (WHO) classes 1,2,3, or 4 OR New York Heart Association (NYHA) classes I, II, III, or IV?
☐ Yes ☐ No

If yes, please provide this information.
If no, please provide clinical support for the use of this drug in your patient.

(if CTEPH) Which of the following applies to your patient:

- ☐ previous surgical treatment
- ☐ inoperable CTEPH
- ☐ neither of the above

Will the requested medication be used in combination with any of the following? (check all that apply):
☐ Adempas
☐ Any phosphodiesterase-5 (PDE5) inhibitors (for example: Adcirca, tadalafil, Revatio, sildenafil, Cialis, Levitra, Staxyn, Stendra, Viagra)

Has your patient had documented failure to any of the following? (check all that apply):
☐ Adcirca ☐ Adempas ☐ bosentan ☐ Alyq ☐ ambrisentan ☐ epoprostenol ☐ Flolan
☐ Letairis ☐ Opsumit ☐ Orenitram ☐ Remodulin ☐ Revatio tablets Revation suspension
☐ sildenafil 20mg tablet ☐ sildenafil oral suspension ☐ tadalafil ☐ Tracleer ☐ Tyvaso
☐ Uptravi ☐ Veletri ☐ Ventavis ☐ other (please specify):_____

Has your patient had documented intolerance to any of the following? (check all that apply):
☐ Adcirca ☐ Adempas ☐ bosentan ☐ Alyq ☐ ambrisentan ☐ epoprostenol ☐ Flolan
☐ Letairis ☐ Opsumit ☐ Orenitram ☐ Remodulin ☐ Revatio tablets Revation suspension
☐ sildenafil 20mg tablet ☐ sildenafil oral suspension ☐ tadalafil ☐ Tracleer ☐ Tyvaso
☐ Uptravi ☐ Veletri ☐ Ventavis ☐ other (please specify):_____

Has your patient had documented contraindication per FDA label to any of the following? (check all that apply):
☐ Adcirca ☐ Adempas ☐ bosentan ☐ Alyq ☐ ambrisentan ☐ epoprostenol ☐ Flolan
☐ Letairis ☐ Opsumit ☐ Orenitram ☐ Remodulin ☐ Revatio tablets Revation suspension
☐ sildenafil 20mg tablet ☐ sildenafil oral suspension ☐ tadalafil ☐ Tracleer ☐ Tyvaso
☐ Uptravi ☐ Veletri ☐ Ventavis ☐ other (please specify):_____

Is your patient able to use any of the following? (check all that apply):
☐ Adcirca ☐ Adempas ☐ bosentan ☐ Alyq ☐ ambrisentan ☐ epoprostenol ☐ Flolan
☐ Letairis ☐ Opsumit ☐ Orenitram ☐ Remodulin ☐ Revatio tablets Revation suspension
☐ sildenafil 20mg tablet ☐ sildenafil oral suspension ☐ tadalafil ☐ Tracleer ☐ Tyvaso
☐ Uptravi ☐ Veletri ☐ Ventavis ☐ other (please specify):_____

If requesting Revatio/sildenafil:
(if requesting vials) Is your patient currently established on oral sildenafil/Revatio? ☐ Yes ☐ No
(if requesting vials) Is your patient temporarily unable to take oral medications? ☐ Yes ☐ No
Does your patient have documented intolerance to either of the following?

- ☐ sildenafil injection
- ☐ sildenafil tablets
- ☐ neither of the above

If requesting epoprostenol, Flolan or Veletri:
Does your patient have congestive heart failure caused by reduced left ventricular ejection fraction? ☐ Yes ☐ No

If requesting Tracleer:
Does your patient have congestive heart failure with left ventricular dysfunction? ☐ Yes ☐ No

(Please note: there are different preferred products depending on your patient's plan. Please refer to the applicable Cigna health care professional resource [e.g. cignaforhcp.com] to determine benefit availability and the terms and conditions of coverage)

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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