



PULMONARY HYPERTENSION AGENTS, ORAL AND INHALED
PRIOR AUTHORIZATION FORM (form effective 1/5/2026)

Prior authorization guidelines for **Pulmonary Hypertension Agents, Oral and Inhaled** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.pa.gov/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services>.

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:			NPI:	State license #:
LTC facility contact/phone:			Street address:	
Beneficiary name:			City/state/zip:	
Beneficiary ID#:		DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug name:	Strength:	Formulation:	
Dose/directions:		Quantity:	Refills:
Diagnosis (<u>submit documentation</u>):		Dx code (<u>required</u>):	
Has the beneficiary been using the requested medication within the past 90 days?		<input type="checkbox"/> Yes	<i>Submit documentation of drug regimen and clinical response.</i>
		<input type="checkbox"/> No	
Is the requested medication prescribed by or in consultation with a practitioner at a Pulmonary Hypertension Association-accredited center or other specialist skilled in treating pulmonary hypertension (i.e., pediatric or adult pulmonologist or cardiologist, rheumatologist)?		<input type="checkbox"/> Yes	<i>Submit documentation of consultation, if applicable.</i>
		<input type="checkbox"/> No	

Complete all sections that apply to the beneficiary and this request.

Check all that apply and submit documentation for each item.

INITIAL requests

1. For treatment of PULMONARY ARTERIAL HYPERTENSION (PAH) (WHO GROUP 1):

- Had a right heart catheterization showing ALL of the following hemodynamic values:
 - Mean pulmonary arterial pressure ≥ 25 mmHg
 - Pulmonary capillary wedge pressure, left atrial pressure, or left ventricular end-diastolic pressure ≤ 15 mmHg
 - Pulmonary vascular resistance >3 Wood units
- Also, for IDIOPATHIC or HERITABLE PAH:**
 - Has chart documentation of acute vasoreactivity testing
 - ONE of the following:
 - Has a contraindication to vasoreactivity testing
 - Is at increased risk of adverse events during acute vasoreactivity testing (e.g., presence of severe [functional class IV] symptoms, low systemic blood pressure, low cardiac index, pulmonary veno-occlusive disease)



- For a beneficiary with idiopathic or heritable PAH who demonstrates acute vasoreactivity:
 Has a history of trial and failure of or contraindication or intolerance to calcium channel blockers (i.e., amlodipine, diltiazem, nifedipine)

2. For treatment of CHRONIC THROMBOEMBOLIC PULMONARY HYPERTENSION (CTEPH):

- Had a right heart catheterization showing BOTH of the following hemodynamic values:
 Mean pulmonary arterial pressure ≥ 25 mmHg
 Pulmonary vascular resistance >3 Wood units

3. For treatment of PULMONARY HYPERTENSION associated with INTERSTITIAL LUNG DISEASE (PH-ILD) (WHO GROUP 3):

- Had a right heart catheterization showing ALL of the following hemodynamic values:
 Mean pulmonary arterial pressure ≥ 25 mmHg
 Pulmonary capillary wedge pressure ≤ 15 mmHg
 Pulmonary vascular resistance >3 Wood units
 Had recent CT imaging demonstrating interstitial lung disease

4. For a NON-PREFERRED Pulmonary Hypertension Agent, Oral and Inhaled:

- Tried and failed or has a contraindication or an intolerance to the preferred Pulmonary Hypertension Agents, Oral and Inhaled (Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred drugs in this class.)

RENEWAL requests

Does the beneficiary continue to benefit from the requested medication?

- Yes *Submit documentation of clinical response.*
 No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:

Date:

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