



Pulmonary Arterial Hypertension Medication Precertification Request Form

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

Please indicate: Start of treatment Continuation of therapy, date of last treatment _____ **Today's date:** _____

Date needed: _____

Ship to: Doctor's office Patient Other: _____ Phone: _____

Dispensing Provider: Aetna Specialty Pharmacy® or Other: _____

Phone: _____ Fax: _____ **TIN:** _____ **PIN:** _____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:		Last Name:	
Address:		City:	State: ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	
Patient Current Weight: _____ lbs or _____ kgs		Patient Height: _____ inches or _____ cms	

B. INSURANCE INFORMATION

Aetna Member ID #: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Circle one): M.D. D.O. N.P. P.A.	
Address:		City:	State:	ZIP:	
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	
Specialty (Check one): <input type="checkbox"/> Cardiologist <input type="checkbox"/> Pulmonologist <input type="checkbox"/> Rheumatologist <input type="checkbox"/> Other: _____					

D. DIAGNOSIS INFORMATION

Primary ICD-9: 416.0 Familial Pulmonary Arterial Hypertension (PAH) 416.0 Idiopathic PAH

Secondary ICD-9: Associated with (select all that apply):

<input type="checkbox"/> _____ Human Immunodeficiency Virus (HIV)	<input type="checkbox"/> _____ Congenital Heart Disease
<input type="checkbox"/> _____ Connective Tissue Disorder	<input type="checkbox"/> _____ Thromboembolic Disease
<input type="checkbox"/> _____ Cirrhosis	<input type="checkbox"/> _____ Anorectic Drugs
<input type="checkbox"/> _____ Other	

E. CLINICAL INFORMATION

Yes No Has patient received a Right Heart Catheterization (RHC) to verify the diagnosis of PAH?
If no, when is the scheduled test date for the RHC? ____ / ____ / ____

Yes No Is the patient unable to tolerate a RHC?

Yes No If prescribing Revatio (sildenafil citrate) or Adcirca (tadalafil), is the patient currently taking organic nitrates (for example, isosorbide mononitrate, isosorbide dinitrate, nitroglycerin)?

Step Therapy does not apply to all plans:
 Yes No If prescribing Revatio (sildenafil citrate), has the patient had an adequate trial and failure of Adcirca (tadalafil)?

F. PRECERTIFICATION REQUESTED FOR (please check all that apply)

<input type="checkbox"/> Adcirca™ PCPB* – PAH Agents	<input type="checkbox"/> Revatio® PCPB* – PAH Agents
<input type="checkbox"/> Floian® CPB # 0184 <input type="checkbox"/> Per Diem S9347	<input type="checkbox"/> Veletri® CPB # 0184
<input type="checkbox"/> Tyvaso™ PCPB* – PAH Agents <input type="checkbox"/> Per Diem S9061	<input type="checkbox"/> Ventavis® PCPB* – PAH Agents <input type="checkbox"/> Per Diem S9347
<input type="checkbox"/> Remodulin® CPB # 0184 <input type="checkbox"/> Per Diem S9347	
<input type="checkbox"/> Letairis® If prescribing Letairis® , please contact LETAIRIS Education and Access Program (LEAP) 1-866-664-LEAP (5327) PCPB* – PAH Agents	
<input type="checkbox"/> Tracleer® If prescribing Tracleer® , please contact Tracleer Access Program (TAP) 1-866-ACTELION (1-866-228-3546) PCPB* – PAH Agents	

*Pharmacy CPB