Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Pulmonary Arterial Hypertension (PAH) Agents Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 1 year; Continuation- 1 year

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Pulmonary Arterial Hypertension (PAH) Agents.** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: http://pithelp.appl.kp.org/MAS/formulary.html**

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Is the provider a pulmonologist or cardiologist, or has the provider consulted with a specialist prior to prescribing?
□ No □ Yes

Provider Name: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

Please check the boxes that apply:
□Initial Request □ Continuation of Therapy Request
□ Standard Review (72 hours)
□ Expedited Review (24 hours): By checking this box, I certify that applying 72 hours standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Provider Signature_____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5 – Diagnosis

Diagnosis of Pulmonary Hypertension?
□ No □ Yes

6 – Clinical Criteria

Is the patient ≥ 18 years old?
□ No □ Yes

Only if requesting injectable Revatio:
Please provide the clinical rationale as to why the sildenafil oral tablet cannot be used.

_____

_____

_____

_____

_____

7 – Provider Sign-Off

Additional Information – Please provide any additional information that should be taken into consideration.

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**