



**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](tel:1-866-331-2104)]. If you have any questions or concerns, please call [1-866-331-2103](tel: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.

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**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:**

Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility