Prescriber Criteria Form Sildenafil PO 2025 PA Fax 641-A v1 010125.docx Revatio (sildenafil citrate) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Revatio (sildenafil citrate).

Drug Name: Revatio (sildenafil citrate)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1)? [If no, then no further questions.]	Yes ◯	No ◯
2	Has pulmonary arterial hypertension (PAH) been confirmed by right heart catheterization? [If no, then no further questions.]	Yes ◯	No ◯
3	Has the patient previously received the requested drug for pulmonary arterial hypertension (PAH)? [If yes, then no further questions.]	Yes ◯	No ◯
4	Does the patient have all of the following: A) pretreatment mean pulmonary arterial pressure greater than 20 millimeters of mercury (mmHg), B) pretreatment pulmonary capillary wedge pressure less than or equal to 15 millimeters of mercury (mmHg)? [If no, then no further questions.]	Yes ◯	No ◯
5	Is the request for an adult patient? [If no, then no further questions.]	Yes ◯	No ◯
6	Does the patient have a pretreatment pulmonary vascular resistance greater than or equal to 3 Wood units?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____