Prescriber Criteria Form Treprostinil BDC 2024 PA Fax 188-A BD-20 v1 010124.docx Remodulin (treprostinil sodium for injection), Treprostinil Sodium For Injection 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 Treprostinil.

Drug Name (select from list of drugs shown):

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.			
B vs D CRITERIA FOR DETERMINATION			
1	Is the requested drug being administered via an infusion pump (excluding disposable pump)? [Note: If using a disposable pump, answer is NO since drugs via a disposable pump are covered under Part D.] [If no, then skip to question 7.]	Yes	No
2	Is the requested drug being administered via an infusion pump in the home (e.g., PATIENT'S HOME, NOT A FACILITY)? [If yes, then skip to question 6.]	Yes	No
3	[The answer to the following question is NO if the patient resides in his/her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution such as an assisted living facility, or an intermediate care facility for individuals with intellectual disabilities (ICF/IID).] Does the patient reside in one of the following skilled nursing facilities (SNF)/skilled care facilities: A) a nursing home that is dually-certified as both a Medicare skilled nursing facility and a Medicaid nursing facility (NF), B) a Medicaid-only NF that primarily furnishes skilled care, C) a non-participating nursing home (i.e., neither Medicare nor Medicaid) that provides primarily skilled care, D) an institution which has a distinct part SNF and which	Yes	No

	also primarily furnishes skilled care? [If no, then skip to question 5.]		
4	Is Medicare Part A paying for the facility bed during the days this treatment is being requested? [If yes, then no further questions.] [If no, then skip to question 7.] [Note: If the answer to this question is yes, then deny and do not process through Part D.]	Yes	No
5	Is the requested drug being supplied from the physician and/or office stock supply and billed as part of a physician service (i.e., the drug is being furnished 'incident to a physician's service')? [If yes, then no further questions.] [If no, then skip to question 7.]	Yes	No
6	Is the requested drug a narcotic analgesic for a non-cancer diagnosis? [If no, then no further questions.]	Yes	No

CRITERIA FOR APPROVAL			
7	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
8	Has pulmonary arterial hypertension (PAH) been confirmed by right heart catheterization? [If no, then no further questions.]	Yes	No
9	Has the patient previously received the requested drug for pulmonary arterial hypertension (PAH)? [If yes, then no further questions.]	Yes	No
10	Does the patient meet all of the following criteria: A) pretreatment mean pulmonary arterial pressure greater than 20 mmHg, B) pretreatment pulmonary capillary wedge pressure less than or equal to 15 mmHg, C) 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:**_____