

Ticket #: _____ Request Date: _____ Request Time: _____

Adcirca® Prior Authorization Request Form (Page 1 of 2)
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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information (required)	
Select the diagnosis below:	
<input type="checkbox"/> Pulmonary arterial hypertension (PAH)	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	

Clinical Information:
Does the patient have pulmonary arterial hypertension (PAH) that is symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No
Was the diagnosis of PAH confirmed by right heart catheterization? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is the patient currently on any therapy for the diagnosis of PAH? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is the requested medication prescribed by or in consultation with a pulmonologist or cardiologist? <input type="checkbox"/> Yes <input type="checkbox"/> No

Reauthorization:
If this is a reauthorization request, answer the following question:
Is there documentation the patient has had a positive clinical response to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No

Quantity Limit Requests:
What is the quantity requested per DAY? _____
What is the reason for exceeding the plan limitations?
<input type="checkbox"/> Titration or loading dose purposes
<input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
<input type="checkbox"/> Requested strength/dose is not commercially available
<input type="checkbox"/> Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Authorized Medical Signature:	
Telephone:	Date:

When Completed Return To:

MC-Rx Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

Please note: This request may be denied unless all required information is received.