Ventavis® (iloprost inhalation solution) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy, Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		DOB:	
Address:		City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:	
Patient Current Weight: ____ lbs or ____ kgs Patient Height: ____ inches or ____ cms			Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____	Does patient have other coverage? ☐ Yes ☐ No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured:	Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name:		*(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.	
Address:			City:	State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one)*: ☐ **Cardiologist** ☐ **Pulmonologist** ☐ **Other:** _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *(Patient selected choice)*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
Phone: _____ FAX: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: Ventavis (iloprost inhalation solution) Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: _____ **Other:** _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For Initiation Requests (clinical documentation required):

☐ Yes ☐ No Is the requested medication prescribed by or in consultation with a pulmonologist or cardiologist?
Please indicate the World Health Organization (WHO) classification of pulmonary hypertension:
Select one: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
☐ Yes ☐ No Does the patient have a diagnosis of pulmonary arterial hypertension (PAH)?
☐ Yes ☐ No Has the diagnosis been confirmed by right heart catheterization?
→ ☐ Yes ☐ No Is the patient an infant less than one year of age?
☐ Yes ☐ No Has Doppler echocardiogram been performed to confirm diagnosis?
→ Please indicate the pretreatment mean pulmonary arterial pressure (mPAP) at rest: ☐ less than or equal to 20mmHg ☐ greater than 20mmHg
Please indicate the pretreatment pulmonary capillary wedge pressure (PCWP): ☐ less than or equal to 15 mmHg ☐ greater than 15 mmHg
Please indicate the pretreatment pulmonary vascular resistance (PVR): ☐ less than 3 Wood units ☐ greater than or equal to 3 Wood units

For Continuation Requests (clinical documentation required):

☐ Yes ☐ No Is the requested medication prescribed by or in consultation with a pulmonologist or cardiologist?
☐ Yes ☐ No Is the patient experiencing benefit from therapy as evidenced by disease stability or disease improvement?

H. ACKNOWLEDGEMENT

Request Completed By ***(Signature Required)***: _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.