Winrevair™ (sotatercept-csrk) Medication Precertification Request

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

Aetna Precertification Notification
Phone: 1-866-752-7021 (TTY: 711)
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 #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
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: Tyvaso (treprostinil 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 ALL Requests (clinical documentation required):

☐ Yes ☐ No Is the requested medication prescribed by or in consultation with a pulmonologist or cardiologist?

For Initiation Requests (clinical documentation required):

Please indicate the World Health Organization (WHO) classification of pulmonary hypertension: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

☐ Yes ☐ No Does the patient have pulmonary hypertension associated with interstitial lung disease?

☐ Yes ☐ No Has the diagnosis been confirmed by right heart catheterization?

→ Please indicate the patient's mean pulmonary arterial pressure (mPAP): ☐ less than or equal to 20mmHg ☐ greater than 20mmHg
Please indicate the patient's pulmonary capillary wedge pressure (PCWP): ☐ less than or equal to 15 mmHg ☐ greater than 15 mmHg
Please indicate the patient's pulmonary vascular resistance (PVR) while stable on at least two pulmonary arterial (PAH) drugs:
☐ less than 3 Wood units ☐ greater than or equal to 3 Wood units

☐ Yes ☐ No Will the requested drug be used as add-on therapy?

☐ Yes ☐ No Is the patient currently receiving pulmonary arterial hypertension (PAH) therapy with drugs from at least two of the following drug classes:
A) Endothelin receptor antagonist (e.g., Letairis, Opsumit, Tracleer), B) Phosphodiesterase-5 inhibitor (e.g., Adcirca, Revatio),
C) Soluble guanylate cyclase stimulator (e.g., Adempas), D) Prostacyclin analog (e.g., Flolan, Orenitram, Remodulin, Tyvaso, Veletri, Ventavis),
E) Prostacyclin receptor agonist (e.g., Uptravi)?

For Continuation Requests (clinical documentation required):

☐ 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.