USFHP Prior Authorization Request Form for Sotatercept-csrk (**Winrevair**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? Call 1-877-880-7007

https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Prior authorization does not expire. Clinical documentation may be required.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Is the patient 18 years of age or older?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Is the prescription written by or in consultation with a cardiologist or pulmonologist?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. Does the patient have confirmed diagnosis of World Health Organization (WHO) Group 1 pulmonary arterial hypertension (PAH)?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Does the patient have confirmed diagnosis of pulmonary arterial hypertension in WHO functional class II or III?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. Has the patient had right heart catheterization?	☐ Yes Proceed to question **6**	☐ No **STOP** Coverage not approved
6. Has documentation been submitted to confirm the patient has had right heart catheterization? NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.	☐ Yes Proceed to question **7**	☐ No **STOP** Coverage not approved

7. Has documentation been submitted to confirm that the patient has a diagnosis of (WHO) Group 1 pulmonary arterial hypertension (PAH)? NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.	☐ Yes Proceed to question **8**	☐ No **STOP** Coverage not approved
8. Has documentation been submitted to confirm the patient is on stable background therapy for PAH (such as, monotherapy, double therapy, triple therapy)? NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.	☐ Yes Proceed to question **9**	☐ No **STOP** Coverage not approved
9. What is the patient's sex?	☐ Female Proceed to question **10**	☐ Male **Sign and date below**
10. Is the patient pregnant?	☐ Yes **STOP** Coverage not approved	☐ No proceed to question **11**
11. Is the patient of childbearing potential?	☐ Yes proceed to question **12**	☐ No **Sign and date below**
12. Does the patient agree to use effective method of contraception during treatment and for at least 4 months after cessation of therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____