



Veletri (epoprostenol), Flolan (epoprostenol) and generics Prior Authorization Form

Complete Patient and Physician Information (PLEASE PRINT)

DOC TYPE IM

Step 1:	
Patient Name:	Physician Name:
Address:	Address:
	NPI#:
Member ID:	Phone #:
Member DOB:	Fax #:
Service Provider Pharmacy Name:	Person completing form:
Pharmacy Phone:	Date of Service:

Step 2:		
Complete the Clinical Assessment		
Diagnosis (please check one)	<input type="checkbox"/> Long-term IV Tx for primary pulmonary hypertension <input type="checkbox"/> Pulmonary HTN associated with the scleroderma spectrum of dz in NYHA Class III & IV patients refractory to conventional therapy	<input type="checkbox"/> Other (please state):
Clinical Consideration	Epoprostenol is a continuous IV infusion therapy that can cost up to \$100,000 per year. Patient's receiving epoprostenol should have certain oversight by a Care Management Nurse to ensure optimization of therapy and a home environment suitable for continuous central line infusion. <input type="checkbox"/> Patient's care is being coordinated by Pulmonologist. <input type="checkbox"/> Patient's home environment is suitable for treatment with IV epoprostenol. <input type="checkbox"/> Care Management Nurse has been notified and will follow patient's course of therapy. <input type="checkbox"/> Nurse:	
	Flolan is now available as a cost saving generic. Thus, epoprostenol should be used unless there is a contraindication to therapy. If this order is for brand name epoprostenol (Flolan or Veletri), please give rationale: <input type="checkbox"/> Patient has tried and failed generic epoprostenol <input type="checkbox"/> Other (please state rationale):	
HCPCS Code =	ICD-9 =	
Supporting Documentation	Please attach a copy of the clinical information or provide ALL of the information below: Product/ Strength _____ Sig _____ Qty _____ Duration _____	
<input type="checkbox"/> Inpatient stay <input type="checkbox"/> Observation stay <input type="checkbox"/> Outpatient services <input type="checkbox"/> Office <input type="checkbox"/> Home		
Please attach all relevant medical records and test results. Incomplete forms will not be processed.		

Step 3
Fax completed form to Rocky Mountain Health Plans: 877-201-7302 or 970-254-5738

The preauthorization for services noted in this form is only for the time period during which the patient remains eligible on the patient's current health benefit plan or for a shorter period as specified in this form. Rocky Mountain Health Plans is not financially responsible for the services that are preauthorized if the patient is not eligible at the date services are provided. Further as permitted by applicable law, this preauthorization is subject to concurrent review as to medical necessity, appropriateness of efficacy and coverage for services being provided and is subject to the terms and conditions in the member's health benefit contract, including but not limited to coordination of benefits, provisions, preexisting conditions and limitations, and any agreements between Rocky Mountain Health Plans and the health care provider. Billing for the services preauthorized on this form is subject to nationally standardized rules for coding and paying health services as used by Rocky Mountain Health Plans.

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