

Sterling Retiree Rx Prior Authorization Form

REVATIO (Sildenafil)

Coverage Criteria / Required Medical Information

Diagnosis of **Pulmonary Arterial Hypertension (PAH)**, (WHO Group 1): PAH confirmed by right heart catheterization **or** if patient is an infant, PAH diagnosed by Doppler echocardiogram **and** if patient is \geq 18 years of age, inadequate response or intolerance to Adcirca.

Exclusion Criteria

concurrent nitrate therapy

Member Information

Name					
Enrollment/Card-holder ID Number					
Group/Plan		Male		Female	
Date of Birth		Age		Weight in Kg	
Street Address					
City		State		Zip	

Physicians Information

Name					
Agent		Contact Name			
Specialty/Office					
Clinic Name					
Street Address					
City		State		Zip	
Phone		Fax			

Requested Drug

REVATIO	Reason for Request	
Condition/Diagnosis Related		

Clinical Drug/Lab History Pertinent to Request

Labs: Baseline/Ongoing	Strength/Dosage		
Formulary Alternative(s) Attempted?	Yes:		No:
Please List Alternative Formulary Drugs			
Comments			

Physicians Signature: _____ **Fax Form to 1-866-481-3704**