Reset Form Print Form

New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form

Winrevair™ (sotatercept-csrk)

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME: **FIRST NAME:**

MEDICAID ID NUMBER: **DATE OF BIRTH:** – –

GENDER: ☐ Male ☐ Female

Drug Name: **Strength:**

Dosing Directions: **Length of Therapy:**

SECTION II: PRESCRIBER INFORMATION

LAST NAME: **FIRST NAME:**

SPECIALTY: **NPI NUMBER:**

PHONE NUMBER: – – **FAX NUMBER:** – – –

SECTION III: CLINICAL HISTORY

1. Does the patient have pulmonary arterial hypertension (PAH) WHO group 1? ☐ Yes ☐ No
2. Has the diagnosis been confirmed by right heart catheterization? ☐ Yes ☐ No

   If *yes*, provide documentation.

   _____
3. Provide the following values attached or in the space provided.

   Pulmonary arterial pressure: _____

   Pulmonary capillary wedge pressure: _____

   Pulmonary vascular resistance: _____
4. Is the patient's PAH considered functional class II or greater? ☐ Yes ☐ No

Phone: 1-866-675-7755 **Fax**: 1-888-603-7696

Review Date: 06/05/2025

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5. Has the patient been on stable background PAH therapy for at least 90 days? ☐ Yes ☐ No
   If yes, list the medications and start dates.

   _____
6. Is the patient a female of reproductive potential? ☐ Yes ☐ No
   If yes, will pregnancy be ruled out before therapy begins? ☐ Yes ☐ No
   Will the patient be educated on contraceptive needs during therapy and for at least 4 months after therapy ends? ☐ Yes ☐ No
7. Will hemoglobin and platelets be monitored throughout therapy? ☐ Yes ☐ No
   Provide the baseline platelet count: _____
8. Is the prescriber a cardiologist or pulmonologist, or has one been consulted? ☐ Yes ☐ No

RENEWAL:

1. Has the patient experienced any treatment-restricting adverse effects? ☐ Yes ☐ No
2. Has the patient benefited from the medication through disease improvement, stabilization, or improvement in the slope of decline? ☐ Yes ☐ No

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

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