

**Physician's Prior Authorization Questionnaire  
Ventavis®**

**Patient:**

**ID#:**

**DOB:**

**Patient Address:**

Ventavis® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patient's diagnosis? *(Please do not use codes.)* \_\_\_\_\_
  
2. Which of the following WHO Group I subcategories of pulmonary arterial hypertension (PAH) does the patient have?
  - a. Idiopathic PAH:
  - b. Familial idiopathic PAH:
  - c. PAH associated with connective tissue disease:
  - d. PAH associated with congenital systemic pulmonary shunts:
  - e. PAH associated with HIV/AIDS:
  - f. PAH associated with previous anorexigen use:
  - g. Other: \_\_\_\_\_
  
3. Does the patient have NYHA Class III or IV symptoms?  Yes  No
  
4. Will any of the medications listed below be used in combination with Venatvis?  Yes  No  
If yes, please mark which one(s):

<input type="checkbox"/> Tadalafil (Adcirca)	<input type="checkbox"/> Sildenafil (Revatio)
<input type="checkbox"/> Epoprostenol (Flolan)	<input type="checkbox"/> Bosentan (Tracleer)
<input type="checkbox"/> Ambrisentan (Letairis)	<input type="checkbox"/> Treprostinil (Tyvaso)
<input type="checkbox"/> Treprostinil (Remodulin)	

***Ventavis® will be shipped to the patient from our Specialty Pharmacy.***

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please **Print** Physician's Name & Specialty

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

**Forms are also available online at [www.usableadmin.com/providers/PharmacyForms.aspx](http://www.usableadmin.com/providers/PharmacyForms.aspx)**