Division: Pharmacy Policy	Subject: Prior Authorization Criteria
Original Development Date: Original Effective Date: Revision Date:	January, 2010 May 2, 2011; June 8, 2012; December 10, 2013, March 5, 2015, March 19, 2015, May 22, 2015, November 25, 2015, February 19, 2016, October 3, 2019, October 21, 2019, January 27, 2020, January 11, 2021, December 8, 2021, January 6, 2022, October 14, 2022, November 13, 2024, March 24, 2025

PULMONARY HYPERTENSION AGENTS

ORAL:

- **Clinical PA required (preferred):** ambrisentan, sildenafil 20mg, tadalafil 20mg, and Tracleer®
- **Non-preferred:** Adcirca®, Adempas®, Alyq®, bosentan, Letairis®, LiQrev®, Opsumit®, Orenitram ER®, Revatio®, Tadliq®, and Uptravi®

INHALED:

- **Clinical PA required (preferred):** Ventavis®
- **Non-preferred:** **Tyvaso®** and **Tyvaso DPI™**

INJECTABLES:

- **Preferred:** Epoprostenol
- **Non-preferred:** Flolan®, Remodulin®, treprostinil, Uptravi®, Veletri® and Winrevair™

LENGTH OF AUTHORIZATION: Up to 1 year

REVIEW CRITERIA:

- Patient must have the diagnosis of pulmonary hypertension.
- Diagnosis must be verified in patient diagnosis code(s) or supporting documentation.
- Verify that medication is prescribed by a related specialist.
- Trial and failure of preferred agent is required (documentation required).
- **If the request is for chronic thromboembolic pulmonary hypertension (CTEPH)**, Adempas may be approved.
- **If the request is for pulmonary hypertension associated with interstitial lung disease**, Tyvaso may be approved.

CONTINUATION OF THERAPY

- Patient met initial review criteria.
- Documentation of improved clinical response.
- Dosing is appropriate as per labeling or is supported by compendia.

DOSING AND ADMINISTRATION:

- Refer to product labeling at https://www.accessdata.fda.gov/scripts/cder/daf/

ADDITIONAL INFORMATION:

Florida Medicaid does not cover treatment for Erectile Dysfunction (ED).