Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

Prior Authorization Form

Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Revatio (Medicare Prior Authorization)
This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at **1-888-836-0730**.
Please contact CVS|Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Revatio (Medicare Prior Authorization).

Drug Name (select from list of drugs shown)
Revatio (sildenafil citrate)

Patient Information

Patient Name: ______________________

Patient ID: ______________________

Patient Group No.: ______________________

Patient DOB: ______________________

Prescribing Physician

Physician Name: ______________________

Physician Phone: ______________________

Physician Fax: ______________________

Physician Address: ______________________

City, State, Zip: ______________________

Diagnosis: ______________________ ICD Code: ______________________

Please circle the appropriate answer for each applicable question.

1. Does the patient have a diagnosis of pulmonary arterial hypertension? Y N
2. Is the pulmonary hypertension associated with any of the following?: Y N
   - Left Heart Disease
   - Chronic Thromboembolic Disease
   - Compression of Pulmonary Vessels (e.g., adenopathy, tumor, fibrosing mediastinitis)
   - Lung Diseases and/or Hypoxemia (e.g., COPD; sleep disorders)
   - Sarcoidosis
3. Does the patient require nitrate therapy on a regular OR on an intermittent basis? Y N

Comments: ______________________

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date