STATEMENT OF MEDICAL NECESSITY (SMN)

ACTELION Pathways®

PATIENT

Last name*: _____ First name*: _____ Birth date*: _____ Gender*: ❒ **Male** ❒ **Female**

Street: _____ City: _____ State: _____ ZIP: _____

Home phone*: (____) _____ Work/cell phone: (____) _____

INSURANCE*

❒ **Insurance card attached (optional: see next page for details)**

Primary insurance: _____

Subscriber name: _____

Name of insured: _____

Policy #: _____

Group #: _____

Phone #: _____

Secondary insurance: _____

Subscriber name: _____

Name of insured: _____

Policy #: _____

Group #: _____

Phone #: _____

PRESCRIPTION*

❒ **VENTAVIS® (iloprost) Inhalation Solution new authorization** ❒ **VENTAVIS re-authorization**

Dose: _____

Frequency: _____

DIAGNOSIS

Primary diagnosis*: _____

_____ ICD9 Code*: _____

Is patient diagnosed with pulmonary arterial hypertension (PAH, WHO Group 1), defined as mean pulmonary arterial pressure ≥25 mmHg, pulmonary arterial wedge pressure ≤15 mmHg, and pulmonary vascular resistance >3 Wood units? ❒ **Yes** ❒ **No**

Is request submitted by, or under the recommendation of, a pulmonologist or cardiologist? ❒ **Yes** ❒ **No**

Right heart catheterization (RHC)

Mean pulmonary artery pressure (mPAP): _____ mmHg

Pulmonary arterial wedge pressure (PAWP): _____ mmHg

Pulmonary vascular resistance (PVR): _____ mmHg

Acute vasoreactivity testing (circle one)

Patient responded Patient did not respond

Date of test: _____

Additional test results

Functional class: _____

Echocardiography: _____ Date: _____

(See enclosed test results)

6-minute walk distance (6MWD): _____ Date: _____

6-minute walk distance (6MWD): _____ Date: _____

PAST TREATMENTS

Ineffective, intolerant, or contraindicated treatments: _____

Reason: _____

Ineffective, intolerant, or contraindicated treatments: _____

Reason: _____

PRESCRIBER*

Last name: _____ First name: _____ Practice name: _____

Specialty: _____

Street: _____ City: _____ State: _____ ZIP: _____

Phone: (____) _____ Fax: (____) _____

Prescriber Tax ID: _____ Prescriber NPI: _____ DEA #: _____

Sign and date here

Prescriber's signature: _____ Date: _____

*Required field(s).

STATEMENT OF MEDICAL NECESSITY (SMN) Instructions

DIAGNOSIS/TREATMENT

- Be sure to include the ICD9 code

- Include any supporting documentation for diagnosis or past treatment. This could include test and lab results, a list of ineffective, intolerant, or contraindicated treatments, or Prescribing Information (typically for new therapies or new indications for existing therapies)

- Echocardiography results may be listed as:
  - PA pressure
  - TR jet
  - Right ventricular systolic pressure (RVSP)

PRESCRIPTION

- Please ensure that all areas of the prescription portion are filled out clearly and completely, including the correct dosage

PRESCRIBER

- This form cannot be processed without an original or stamped signature

ATTACH TO COMPLETED SMN

- Attach a signed and dated letter

- Be sure to use the prior authorization (PA) form provided by the insurance company

- If the patient is insured, include the patient ID number from his or her insurance card