

PA DEPARTMENT OF HUMAN SERVICES  
MAAC BRIEFING DOCUMENT  
PULMONARY HYPERTENSION AGENTS, ORAL AND INHALED

**Proposed Effective Date:** January 5, 2026

Revisions are noted with a ~~strikethrough~~ for deletions and **bold and underline** for additions.

**I. Requirements for Prior Authorization of Pulmonary Hypertension Agents, Oral and Inhaled**

A. Prescriptions That Require Prior Authorization

All prescriptions for Pulmonary Hypertension Agents, Oral and Inhaled must be prior authorized.

B. Revisions to Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Pulmonary Hypertension Agent, Oral and Inhaled, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. **One** of the following:
  - a. Is prescribed the Pulmonary Hypertension Agent, Oral and Inhaled for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication, excluding use to treat sexual or erectile dysfunction
  - b. For the treatment of pulmonary arterial hypertension (PAH), is prescribed a Pulmonary Hypertension Agent, Oral and Inhaled that is appropriate for the beneficiary's **clinical status** ~~level of risk based on current risk calculator assessment (e.g., REVEAL 2.0) and current peer-reviewed medical literature;~~

**AND**

2. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**
3. **One** of the following:
  - a. If under 18 years of age, is prescribed the Pulmonary Hypertension Agent, Oral and Inhaled by or in consultation with a pediatric pulmonologist; **or** pediatric cardiologist; ~~or heart and lung transplant specialist skilled in treating pulmonary hypertension~~
  - b. If 18 years of age or older, **one** of the following:
    - i. Is prescribed the Pulmonary Hypertension Agent, Oral and Inhaled by or in consultation with a practitioner at a Pulmonary Hypertension Association-accredited center
    - ii. If unable to access a Pulmonary Hypertension Association-accredited center, is

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prescribed the Pulmonary Hypertension Agent, Oral and Inhaled by or in consultation with an appropriate specialist (i.e., pulmonologist, cardiologist, or rheumatologist) skilled in treating pulmonary hypertension;

**AND**

4. Does not have a contraindication to the prescribed drug; **AND**
5. For a diagnosis of PAH (WHO Group 1), **all** of the following:
  - a. Has chart documentation of right heart catheterization indicating **all** of the following hemodynamic values:
    - i. A mean pulmonary arterial pressure (**mPAP**) greater than or equal to ~~20~~ **25** mmHg,
    - ii. A pulmonary capillary wedge pressure (**PCWP**), left atrial pressure, or left ventricular end-diastolic pressure less than or equal to 15 mmHg,
    - iii. A pulmonary vascular resistance (**PVR**) greater than ~~or equal to~~ 3 Wood units,
  - b. ~~For a beneficiary with idiopathic PAH, both of the following:~~
    - i. ~~One of the following:~~
      - a) ~~Has a H<sub>2</sub>FPEF score less than 2;~~
      - b) ~~Has a left atrial volume index less than 35 mL/m<sup>2</sup>;~~
      - c) ~~Has a negative provocative test in a heart catheterization lab (fluid challenge with pulmonary capillary wedge pressure, left atrial pressure, or left ventricular end-diastolic pressure less than or equal to 17 mmHg)~~
  - c. **For a beneficiary with idiopathic or heritable PAH, one** of the following:
    - i. Has chart documentation of acute vasoreactivity testing
    - ii. Has a contraindication to vasoreactivity testing or is at increased risk of adverse events during acute vasoreactivity testing (~~[e.g., high risk stratification based on current risk calculator assessment (e.g., REVEAL 2.0),~~ **presence of severe (functional class IV) symptoms,** low systemic blood pressure, low cardiac index, or pulmonary veno-occlusive disease~~]~~),
  - d. For a beneficiary with idiopathic **or heritable** PAH that demonstrates acute vasoreactivity,<sup>1</sup> has a documented history of therapeutic failure of or a contraindication or an intolerance to calcium channel blockers (i.e., amlodipine, nifedipine, or diltiazem);

**AND**

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<sup>1</sup> A positive vasoreactivity test is defined by a decrease in the mean pulmonary artery pressure by at least 10 mmHg to reach an absolute value of 40 mmHg or less without a decrease in cardiac output.

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6. For a diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH), has chart documentation of right heart catheterization indicating **both** of the following hemodynamic values:
- a. An **mPAP** ~~mean pulmonary arterial pressure~~ greater than **or equal to 20 25** mmHg
  - b. A **PVR** ~~pulmonary vascular resistance~~ greater than ~~or equal to~~ 3 Wood units;

**AND**

7. **For a diagnosis of pulmonary hypertension associated with interstitial lung disease (PH-ILD; WHO Group 3), has both of the following:**
- a. **Chart documentation of right heart catheterization indicating all of the following hemodynamic values:**
    - i. **An mPAP greater than or equal to 25 mmHg.**
    - ii. **A PCWP less than or equal to 15 mmHg.**
    - iii. **A PVR greater than 3 Wood units**
  - b. **Chart documentation of recent computed tomography (CT) imaging demonstrating interstitial lung disease;**

**AND**

8. For a non-preferred Pulmonary Hypertension Agent, Oral and Inhaled, **one** of the following:
- a. Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Pulmonary Hypertension Agents, Oral and Inhaled approved or medically accepted for the beneficiary's diagnosis or indication
  - b. Has a current history (within the past 90 days) of being prescribed the same non-preferred Pulmonary Hypertension Agent, Oral and Inhaled (does not apply to non-preferred brands when the therapeutically equivalent generic is preferred or to non-preferred generics when the therapeutically equivalent brand is preferred).

See the Preferred Drug List (PDL) for the list of preferred Pulmonary Hypertension Agents, Oral and Inhaled at: <https://papdl.com/preferred-drug-list>;

**AND**

9. If the prescription for a Pulmonary Hypertension Agent, Oral and Inhaled is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter. The list of drugs that are subject to quantity limits, with accompanying quantity limits, is available at: <https://www.pa.gov/en/agencies/dhs/resources/pharmacy-services/quantity->

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[limits-daily-dose-limits.html](#).

NOTE: If the beneficiary does not meet the clinical review guidelines above but, in the professional judgement of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR PULMONARY HYPERTENSION AGENTS, ORAL AND INHALED: The determination of medical necessity of a request for renewal of a prior authorization for a Pulmonary Hypertension Agent, Oral and Inhaled that was previously approved will take into account whether the beneficiary:

1. Continues to benefit from the requested Pulmonary Hypertension Agent, Oral and Inhaled based on the prescriber's assessment; **AND**
2. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**
3. **One** of the following:
  - a. If under 18 years of age, is prescribed the Pulmonary Hypertension Agent, Oral and Inhaled by or in consultation with a pediatric pulmonologist; or pediatric cardiologist; ~~or heart and lung transplant specialist~~
  - b. If 18 years of age or older, **one** of the following:
    - i. Is prescribed the Pulmonary Hypertension Agent, Oral and Inhaled by or in consultation with a practitioner at a Pulmonary Hypertension Association-accredited center
    - ii. If unable to access a Pulmonary Hypertension Association-accredited center, is prescribed the Pulmonary Hypertension Agent, Oral and Inhaled by or in consultation with an appropriate specialist (i.e., pulmonologist, cardiologist, or rheumatologist);

**AND**

4. Does not have a contraindication to the prescribed drug; **AND**
5. For a non-preferred Pulmonary Hypertension Agent, Oral and Inhaled with a therapeutically equivalent brand or generic that is preferred on the PDL, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred therapeutically equivalent brand or generic that would not be expected to occur with the requested drug. See the PDL for the list of preferred Pulmonary Hypertension Agents, Oral and Inhaled at <https://papdl.com/preferred-drug-list>; **AND**

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6. If the prescription for a Pulmonary Hypertension Agent, Oral and Inhaled is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter. The list of drugs that are subject to quantity limits, with accompanying quantity limits, is available at: <https://www.pa.gov/en/agencies/dhs/resources/pharmacy-services/quantity-limits-daily-dose-limits.html>.

NOTE: If the beneficiary does not meet the clinical review guidelines above but, in the professional judgement of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for a Pulmonary Hypertension Agent, Oral and Inhaled. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

D. References

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