Blue Cross and Blue Shield of Vermont and The Vermont Health Plan
Prior Approval Form
Flolan® (epoprostenol sodium)

BCBSVT and TVHP Fax # (888)–255-1006

PLEASE COMPLETE THE FOLLOWING SECTIONS:

Date of Request _______________ Patient Name: ___________________________

BCBSVT/TVHP Member ID#:_______________ Date of birth:_____________________

Provider Name:___________________________ Provider Phone number:___________________

Provider Fax number:_____________________ PCP Name: ______________________________

Patient Weight: ____________________

INDICATIONS FOR USE	YES	NO
1. Treatment of primary pulmonary hypertension in patients who are not responding to conventional therapy.	☐	☐
2. Treatment of secondary pulmonary hypertension due to intrinsic pre-capillary pulmonary vascular disease.	☐	☐
3. **Will Prescription be dispensed at (circle one): Provider Office Network Pharmacy**		

CONTRAINDICATIONS FOR USE	YES	NO
1. Hypersensitivity to epoprostenol to structurally related compounds.	☐	☐
2. Chronic use in patients with CHF due to severe left ventricular systolic dysfunction.	☐	☐

If criteria are met, epoprostenol sodium therapy approval is for 12 months.

Dose: ________ Frequency: _________ Duration of Therapy: _________

PRESCRIBER SIGNATURE____ DATE______________

By signing above, the prescriber confirms all information provided is accurate and verifiable via member records.

BlueCross BlueShield of Vermont
Independent Licensees of the Blue Cross and Blue Shield Association.