



Please complete ALL information below and fax your request to 1-888-671-5285

Adempas® Coverage Determination Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:	Office Contact:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name: Select one of the following: <input type="checkbox"/> Request is for GENERIC <input type="checkbox"/> Request is for BRAND (unable to take the generic)	Strength:	Dosage Form:
<input type="checkbox"/> Check if request is for continuation of therapy	Directions for Use:	

Clinical Information (required)
Select the Type of Coverage Determination Requested: <input type="checkbox"/> Prior Authorization- Request is for a drug that requires prior authorization under the plan.
Select the diagnosis below: <input type="checkbox"/> Chronic thromboembolic pulmonary hypertension (CTEPH) <input type="checkbox"/> Pulmonary arterial hypertension (PAH) <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____
For chronic thromboembolic pulmonary hypertension (CTEPH), answer the following: Does the patient have a diagnosis of persistent/recurrent CTEPH (WHO Group 4) after surgical treatment or inoperable CTEPH? <input type="checkbox"/> Yes <input type="checkbox"/> No Will the patient use Adempas concurrently with phosphodiesterase inhibitors, nitrates, or nitric oxide donors? <input type="checkbox"/> Yes <input type="checkbox"/> No If female: Is the patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
For pulmonary arterial hypertension (PAH), answer the following: Does the patient have a diagnosis of PAH WHO Group I with New York Heart Association (NYHA) Functional Class II-IV? <input type="checkbox"/> Yes <input type="checkbox"/> No Was the patient's diagnosis confirmed by catheterization (right-heart or Swan-Ganz) or echocardiography? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have a mean pulmonary artery pressure greater than or equal to 25 mm Hg at rest or greater than 30 mm Hg with exertion? <input type="checkbox"/> Yes <input type="checkbox"/> No Will the patient use Adempas concurrently with phosphodiesterase inhibitors, nitrates, or nitric oxide donors? <input type="checkbox"/> Yes <input type="checkbox"/> No If female: Is the patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
Reauthorization: Is there documentation the patient has stabilization or improvement as evaluated by a cardiologist or pulmonologist? <input type="checkbox"/> Yes <input type="checkbox"/> No Will the patient use Adempas concurrently with phosphodiesterase inhibitors, nitrates, or nitric oxide donors? <input type="checkbox"/> Yes <input type="checkbox"/> No If female: Is the patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.

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