FUTURE SCRIPTS Secure

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)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:	Office Contact:	
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type of Coverage Determination Requested:

❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

Select the diagnosis below:

❑ Chronic thromboembolic pulmonary hypertension (CTEPH)

❑ Pulmonary arterial hypertension (PAH)

❑ 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? ❑ **Yes** ❑ **No**

Will the patient use Adempas concurrently with phosphodiesterase inhibitors, nitrates, or nitric oxide donors? ❑ **Yes** ❑ **No**

If female: Is the patient pregnant? ❑ **Yes** ❑ **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? ❑ **Yes** ❑ **No**

Was the patient's diagnosis confirmed by catheterization (right-heart or Swan-Ganz) or echocardiography? ❑ **Yes** ❑ **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? ❑ **Yes** ❑ **No**

Will the patient use Adempas concurrently with phosphodiesterase inhibitors, nitrates, or nitric oxide donors? ❑ **Yes** ❑ **No**

If female: Is the patient pregnant? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation the patient has stabilization or improvement as evaluated by a cardiologist or pulmonologist? ❑ **Yes** ❑ **No**

Will the patient use Adempas concurrently with phosphodiesterase inhibitors, nitrates, or nitric oxide donors? ❑ **Yes** ❑ **No**

If female: Is the patient pregnant? ❑ **Yes** ❑ **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.