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

Letairis® (ambrisentan), Opsumit®, Orenitram®, & Tracleer® (bosentan) 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: ❑ 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:

❑ Pulmonary arterial hypertension (PAH)

❑ Other diagnosis: ____ ICD-10 Code(s): _________________________________

Prescriber's Specialty:

Select if the requested medication is prescribed by one of the following specialists:

- ❑ Cardiologist
- ❑ Pulmonologist

Clinical Information:

Does the patient have a diagnosis of pulmonary arterial hypertension (PAH) WHO Group I with New York Heart Association (NYHA) functional Class II to IV? ❑ **Yes** ❑ **No**

Has the diagnosis been confirmed by catheterization (right-heart or Swan-Ganz) OR echocardiography? ❑ **Yes** ❑ **No**

Select if there is documentation the patient has one of the following:

- ❑ Mean pulmonary artery pressure greater than or equal to 25 mm Hg at rest
- ❑ Mean pulmonary artery pressure greater than 30 mm Hg with exertion

Reauthorization:

If this is a reauthorization request, answer the following:

Is there documentation of stabilization or improvement as evaluated by a cardiologist or pulmonologist? ❑ **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?

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

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