



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

Opsumit® Prior Authorization Request Form

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

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if generic substitution is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)

Select the diagnosis below:

- Pulmonary arterial hypertension (PAH)
- Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

- Does the patient have pulmonary arterial hypertension (PAH) that is symptomatic? Yes No
- Was the diagnosis of PAH confirmed by right heart catheterization? Yes No
- Is the patient currently on any therapy for the diagnosis of PAH? Yes No
- Is the requested medication prescribed by or in consultation with a pulmonologist or cardiologist? Yes No

Reauthorization:

- Is there documentation the patient has a positive clinical response to therapy? Yes No

Quantity Limit Requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

- Titration or loading dose purposes
- Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- Requested strength/dose is not commercially available
- Other: _____

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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