Opsumit (macitentan)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Pulmonary arterial hypertension (PAH) ☐ Other diagnosis: _____ICD-10_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Is the requested medication prescribed by a pulmonologist, cardiologist, nephrologist, or rheumatologist? ☐ Yes ☐ No

Does the patient have a diagnosis of pulmonary arterial hypertension (WHO Group 1)? ☐ Yes ☐ No
Please submit documentation.

Select if the patient has any of the following causes for pulmonary arterial hypertension (PAH):
Please submit documentation.
☐ Idiopathic/Primary PAH
☐ Drugs and toxin induced
☐ Connective tissue disease (e.g., Lupus/SLE, RA scleroderma, systemic sclerosis, CREST syndrome, polymyositis, polyarteritis nodosa, mixed connective tissue disease)
☐ HIV infection
☐ Portal hypertension
☐ Congenital heart disease(e.g. atrial septal defect)
☐ Associated with surgical repair of a congenital systemic-to-pulmonary shunt of at least 1 year in duration(e.g. ventricular septal defect, patent ductus arteriousus)
☐ Schistosomiasis
☐ Chronic hemolytic anemia

Does the patient experience WHO Functional Class II through IV symptoms? ☐ Yes ☐ No
Please submit documentation.

Select if the patient's cardiac catheterization report meets any of the following:*
Does patient have, (at rest), measured by cardiac catheterization a mean pulmonary artery pressure(mPAP of 20mmHg or greater via right heart cath to confirm PAH? ☐ Yes ☐ No **Please provide documentation.*

Does patient have, (at rest), measured by cardiac catheterization a pulmonary capillary wedge pressure(PCWP) 15mmHg or less via right heart cath to confirm PAH? ☐ Yes ☐ No **Please provide documentation.*

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Does patient have, (at rest), measured by cardiac catheterization a pulmonary vascular resistance(PVR) value equaling 3 wood units or greater via right heart cath to confirm PAH? □ Yes □ No *Please provide documentation.*

If patient has idiopathic PAH, hereditaryPAH(excludes congenital heart disease like atrial=septal defect) or drug/toxin induced PAH, did patient have had an acute vasoreactivity test? □ Yes □ No *Please provide documentation.*

Has patient been previously treated with a Calcium channel blocker? □ Yes □ No *Please provide documentation.*

For Letairis, also answer the following:
Is the patient enrolled in the Letairis REMS program? □ 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: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ Date: _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

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