Orenitram (treprostinil)
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 prescribing physician a specialist in one of the following fields: pulmonology, cardiology, nephrology, or rheumatology? ☐ Yes ☐ No

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

Select if the patient has the following causes for pulmonary arterial hypertension (PAH):

- **☐ Idiopathic/primary PAH**
- **☐ Drugs and toxins induced(not reactive to acute vasoreactivity testing (AVT) or failed calcium channel blocker)CCB treatment)**
- **☐ 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)**
- **☐ Schistosomiasis**
- **☐ Associated with surgical repair of a congenital systemic-to-pulmonary shunt of at least 1year in duration (e.g., ventricular septal defect, patent ductus arteriosus)**
- **☐ Chronic hemolytic anemia**

Is patient WHO functional class II thru IV? ☐ Yes ☐ No please provide documentation.

Does patient have a mean pulmonary artery pressure (mPAP) equaling 25 mmHg or greater? ☐ Yes ☐ No Please provide cardiac catheterization report.

Does patient have a pulmonary capillary wedge pressure (PCWP) equaling 15 mmHg or less? ☐ Yes ☐ No Please provide cardiac catheterization report.

Does patient have a pulmonary vascular resistance (PVR) equaling 3 Wood units via right heart cath or greater? ☐ Yes ☐ No Please provide cardiac catheterization report.

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Does patient have a history of left-sided heart disease? □ Yes □ No Please provide documentation.

Does patient have severe renal insufficiency? □ Yes □ No please provide documentation.

Has patient had an inadequate response or intolerance to a PDE5 inhibitor such as Revatio(sildenafil and/or Adcirca(tadalafil)? □ Yes □ No Please provide documentation.

Does patient have contraindications to PDE5 inhibitors Revatio(sildenafil and/or Adcirca(tadalafil)? □ Yes □ No Please provide documentation.

Has patient had an inadequate response or intolerance to Adempas (riociguat) ? □ Yes □ No Please provide documentation.

Does patient have contraindications to Adempas (riociguat)? □ Yes □ No Please provide documentation.

Has patient had an inadequate response or intolerance to an endothelin receptor antagonist [e.g., Letairis (ambrisentan), Opsumit (macitentan), or Tracleer (bosentan)]? □ Yes □ No Please provide documentation.

Does patient have contraindications to an endothelin receptor antagonist [e.g., Letairis (ambrisentan), Opsumit (macitentan), or Tracleer (bosentan)]? □ Yes □ No Please provide documentation.

Will Orenitram(treprostinil) be taken in combination with a prostanoid/prostacyclin analogue (e.g., epoprostenol, iloprost, treprostinil, and/or selexipag)? □ Yes □ No Please provide documentation.

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