



Tracleer (bosentan) 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](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:
<input type="checkbox"/> NEW THERAPY <input type="checkbox"/> RENEWAL		IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.





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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:
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2. LIST DIAGNOSES: **ICD-10:**

<input type="checkbox"/> Pulmonary arterial hypertension (PAH) <input type="checkbox"/> Other diagnosis: _____ ICD-10 _____	
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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 arteriosus)
- 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, hereditary PAH(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.*

Renewal Criteria for Tracleer Suspension:

Is patient still under the age of 18? Yes No

Does the patient have difficulty swallowing tablets? Yes No

Is patient unable to obtain the required treatment dosage with Tracleer(bosentan) tablets, where the suspension formulation is able to meet the correct dosage? 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:** _____

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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

