Uptravi (selexipag)
Prior Authorization Request Form

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

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

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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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 □ Other diagnosis: _____ICD-10_____	

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

Clinical Information:

Is Uptravi being 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

Select if the patient's pulmonary arterial hypertension (PAH) was caused by the following:

- **□ Idiopathic/Primary PAH**
- **□ Drug- 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**
- **□ Schistosomiasis**
- **□ Chronic hemolytic anemia**

Does the patient experience WHO Functional Class II through IV symptoms? □ Yes □ No

Select if the patient's cardiac catheterization report meets any of the following:*

- **□ MPAP 25 mmHg or greater + PCWP less than 19 mmHg/LVEDP not reported**
- **□ MPAP 25 mmHg or greater + LVEDP less than 19 mmHg/PCWP not reported**
- **□ MPAP 25 mmHg or greater + PCWP less than 19 mmHg + LVEDP less than 19 mmHg**

Please provide a copy of the report.

Has the patient tried and had an inadequate response or intolerance to PDE5 inhibitor (i.e. Revatio, Adcirca) OR Adempas (riociguat)?* □ Yes □ No
Please provide documentation.

Does the patient have a contraindication to treatment with BOTH a PDE5 inhibitor (i.e. Revatio, Adcirca) and Adempas (riociguat)?* □ Yes □ No
Please submit documentation of the contraindication.

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Has the patient tried and 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 the patient have a contraindication to treatment w ith an endothelin receptor antagonist [e.g., Letairis (ambrisentan), Opsumit (macitentan), or Tracleer (bosentan)]?* □ **Yes** □ **No**
Please submit documentation of the contraindication.

Will Uptravi be taken in combination w ith a prostanoid/prostacyclin analogue (e.g., epoprostenol, iloprost, treprostinil)? □ **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/diagnoses 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