Adempas (Riociguat)
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:	

Continued on next page.

Adempas (Riociguat)
Prior Authorization Request Form

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

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:**
☐ Chronic thromboembolic pulmonary hypertension (CTEPH) ☐ Pulmonary arterial hypertension (PAH) ☐ Other diagnosis: _____ICD-10 Code(s):	

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

For <u>chronic thromboembolic pulmonary hypertension (CTEPH)</u>, answer the following:
Is the prescribing physician a specialist in pulmonology or cardiology? ☐ Yes ☐ No

Select if one of the following sets of measurements (at rest) measured by cardiac catheterization to confirm PAH:*
☐ 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 mm/Hg
A copy of the cardiac catheterization report must be included.

Will the patient discontinue other medications used to treat CTEPH including Revatio (sildenafil), Adcirca (tadalafil), Opsumit, Tracleer, Letairis, Remodulin, Flolan, Tyvaso, or Ventavis? ☐ Yes ☐ No
Has the patient had an endarterectomy? ☐ Yes ☐ No
Does the patient have severe lung disease, a low degree of proximal obstruction, or a high degree of microvascular obstruction?* ☐ Yes ☐ No
Please provide documentation.

For <u>pulmonary arterial hypertension</u>, answer the following:
Select the prescriber's specialty:
☐ Cardiology ☐ Nephrology ☐ Pulmonology ☐ Rheumatology

Select if the diagnosis of Group 1 pulmonary arterial hypertension (PAH) is caused by one of the follow ing etiologies:*
☐ Chronic hemolytic anemia
☐ Congenital heart disease
☐ Drugs and toxins induced
☐ HIV infection
☐ Idiopathic/primary PAH
☐ Portal hypertension
☐ Schistosomiasis
☐ Tissue disease (e.g., lupus/SLE, RA scleroderma, systemic sclerosis, CREST syndrome, polymositis, polyarteritis nodosa, mixed connective tissue disease)
Please provide documentation

Select if the one of the follow ing sets of measurements (at rest) measured by cardiac catheterization to confirm PAH:*

□ **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**

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; c/o Magellan Health, Inc.
4801 E. Washington Street, Phoenix, AZ 85034
Phone: 877-228-7909