

Letairis (ambrisentan) 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.

			URGEN	
MEMBER INFORMATION				
LAST NAME:		FIRST NAME:		
PHONE NUMBER:		DATE OF BIRTH:		
STREET ADDRESS:				
CITY:		STATE: ZIP CO	DDE:	
PATIENT INSURANCE ID	NUMBER:			
MALE FEMALE	HEIGHT (IN/CM): W	EIGHT (LB/KG): ALLE	ERGIES:	
		DISCLOSURE AUTHORIZATION FORM WITH THI OMMON/DOC/EN-US/PHI_DISCLOSURE_AUTH		
		BLE):		
PRESCRIBER INFORMATI	ON			
LAST NAME:		FIRST NAME:	FIRST NAME:	
PRESCRIBER SPECIALTY:		EMAIL ADDRESS:	EMAIL ADDRESS:	
NPI NUMBER:		DEA NUMBER:		
PHONE NUMBER:		FAX NUMBER:	FAX NUMBER:	
STREET ADDRESS:				
CITY:		STATE: ZIP CO	DDE:	
REQUESTOR (if different than prescriber):		OFFICE CONTACT PERSO	OFFICE CONTACT PERSON:	
		1		
MEDICATION OR MEDIC	AL DISPENSING INFORMATIO	N		
MEDICATION NAME:				
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:	
NEW THERAPY RENEWAL DURATION OF THERAPY (SPECIFIC DATES):		IF RENEWAL: DATE THER	IF RENEWAL: DATE THERAPY INITIATED:	
Continued on next page.				

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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:		
1. HAS THE PATIENT TRIED ANY OTHE	ER 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:ICE)-10		
3. REQUIRED CLINICAL INFORMATION PRIOR AUTHORIZATION.	N: PLEASE PROVIDE ALL RELEVANT CLINIC	CAL INFORMATION TO SUPPORT A	
No	ed by a pulmonologist, cardiologist, nep		
Please submit documentation. Idiopathic/Primary PAH Drugs and toxin induced Connective tissue disease (e.g., Luppolyarteritis nodosa, mixed connective HIV infection Portal hypertension Congenital heart disease(e.g. atrial	septal defect) congenital systemic-to-pulmonary shun	sis, CREST syndrome, polymyositis,	
,	nctional Class II through IV symptoms?	⊒ Yes □ No	
Does patient have, (at rest), measure	rization report meets any of the following by cardiac catheterization a mean public th to confirm PAH? Yes No *Please	monary artery pressure(mPAP of	
	ed by cardiac catheterization a pulmonar o confirm PAH? Yes No *Please pro		

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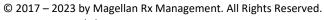
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equaling 3 wood units or greater via right heart cath to confirm PAH? Y	•		
If patient has idiopathic PAH, hereditaryPAH(excludes congenital heart di	isease like atrial=septal defect) or		
drug/toxin induced PAH, did patient have had an acute vasoreactivity tes	•		
documentation.			
Has patient been previously treated with a Calcium channel blocker? \Box Yo	es 🗆 No *Please provide documentation.		
For Letairis, also answer the following:			
Is the patient enrolled in the Letairis REMS program? \Box Yes \Box No			
Are there any other comments, diagnoses, symptoms, medications tried physician feels is important to this review?	or failed, and/or any other information the		
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 th	e 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 o	•		
Prescriber Signature or Electronic I.D. Verification:	Date:		
CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidence.	ential health information that is legally privileged. If		
you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents			
of these documents is strictly prohibited. If you have received this information in error, plea	ase notify the sender immediately (via return FAX)		
and arrange for the return or destruction of these documents.			

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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