

Opsumit (macitentan) 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:	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:		
NPI NUMBER:		DEA NUMBER:		
PHONE 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	R 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	TCD-10.	
PRIOR AUTHORIZATION.	: PLEASE PROVIDE ALL RELEVANT CLINICA	AL INFORMATION TO SUPPORT A	
Clinical Information: Is the requested medication prescribe No	ed by a pulmonologist, cardiologist, neph	nrologist, or rheumatologist? Yes	
Does the patient have a diagnosis of p Please submit documentation.	oulmonary arterial hypertension (WHO C	Group 1)? □ Yes □ No	
Please submit documentation. Idiopathic/Primary PAH Drugs and toxin induced Connective tissue disease (e.g., Lupupolyarteritis nodosa, mixed connective HIV infection Portal hypertension Congenital heart disease(e.g. atrial section)	septal defect) congenital systemic-to-pulmonary shun	sis, CREST syndrome, polymyositis,	
Does the patient experience WHO Fur Please submit documentation.	nctional Class II through IV symptoms?] Yes □ No	
Does patient have, (at rest), measured	rization report meets any of the followind by cardiac catheterization a mean pulner the confirm PAH? Yes No *Please	monary artery pressure(mPAP of	
1	d by cardiac catheterization a pulmonary confirm PAH? Yes No *Please pro		

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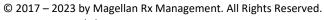
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If patient has idiopathic PAH, hereditaryPAH(excludes congenital heart disease like atrial=septal defect) or drug/toxin induced PAH, did patient have had an acute vasoreactivity test? Yes No *Please provide documentation. Has patient been previously treated with a Calcium channel blocker? Yes No *Please provide documentation. For Letairis, also answer the following: Is the patient enrolled in the Letairis REMS program? 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: CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential 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	equaling 3 wood units or greater via right heart cath to confirm PAH? Yes No *Please provide documentation.
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of those decuments is strictly prohibited. If you have received this information in arror, please notify the conder immediately (via return EAV)	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, please notify the sender immediately (via return FAX)

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



and arrange for the return or destruction of these documents.

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