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:** ____________________________

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: PRIMETHERAPEUTICS.COM/NOPP

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**	**IF RENEWAL:** DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

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Prime THERAPEUTICS™

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.

Is patient going to be using drug in a clinical trial? □ **Yes** □ **No**

For chronic thromboembolic pulmonary hypertension (CTEPH), 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** ***If patient has not had an endarterectomy, please provide documentation why patient was not a candidate.***

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.

Does patient have an angiography report or ventilation-perfusion scintigraphy report? □ **Yes** □ **No**
Please provide documentation

For pulmonary arterial hypertension, answer the following:
Select the prescriber's specialty:

□ **Cardiology** □ **Nephrology** □ **Pulmonology** □ **Rheumatology**

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Select if the diagnosis of Group 1 pulmonary arterial hypertension (PAH) is caused by one of the following etiologies:*

□ Chronic hemolytic anemia

□ Congenital heart disease(e.g. atrial septal defect)

□ Drugs and toxins induced(not reactive to acute vasoreactivity testing(AVT) or failed calcium channel blocker)CCB treatment)

□ HIV infection

□ Idiopathic/primary PAH

□ Portal hypertension

□ Schistosomiasis

□ Associated with surgical repair of a congenital systemic-to-pulmonary shunt of at least 1year in duration(e.g., ventricular septal defect, patent ductus arteriosus)

□ Tissue disease (e.g., lupus/SLE, RA scleroderma, systemic sclerosis, CREST syndrome, polymositis, polyarteritis nodosa, mixed connective tissue disease)

Please provide documentation

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.*

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.*

Is patient WHO functional class II thru IV? □ Yes □ No *Please provide documentation.*

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.*

Has patient been previously treated with a phosphodiesterase-5 inhibitor(PDE-5) such as Revatio(sildenafil) or Adcirca(tadalafil)? □ Yes □ No *Please provide documentation.*

Does patient have an absolute contraindication to a PDE-5 inhibitor? □ Yes □ No *Please provide documentation.*

Has patient been previously treated with an endothelin receptor antagonist(ERA) such as Opsumit(macitentan), Tracleer(bosentan) or Letairis(ambrisentan)? □ Yes □ No *Please provide documentation.*

Does patient have an absolute contraindication to an ERA? □ Yes □ No *Please provide documentation.*

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Does patient have a history of left-sided heart disease? □ **Yes** □ **No**

Does patient have severe renal insufficiency? □ **Yes** □ **No**

Does patient have pulmonary hypertension related to conditions other than previously specified? □ **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: Prime Therapeutics Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
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