CareSource Rxinnovations

INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT
PULMONARY ANTIHYPERTENSIVES PRIOR AUTHORIZATION REQUEST FORM

CareSource Pharmacy Prior Authorization Form
P.O. Box 8738
Dayton, OH 45401-8738
Fax: (866) 930-0019

Today's Date ☐☐ / ☐☐ / ☐☐☐☐ Non-Urgent ☐ Urgent ☐

Note: This form must be completed by the prescribing provider.

*****All sections must be completed or the request will be returned.*****

Patient's CareSource # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Office Contact
Prescriber's Fax ☐☐☐ - ☐☐☐ - ☐☐☐☐	Prescriber's Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐
Prescriber's Address	Date(s) of Service: _____ Start Date: _____

Requested Medication	Strength	Quantity	Dosage Regimen

General information applicable to all products:

Pulmonary Antihypertensive PA Requirements:

1. Member has a diagnosis of pulmonary hypertension □ Yes □ No
   Diagnosis Code: _____
2. Member has a diagnosis of pulmonary hypertension associated with interstitial lung disease (only applicable to Tyvaso/Tyvaso DPI) □ Yes □ No
3. Requested agent has been prescribed by, or in consultation with, a pulmonologist or cardiologist ☐ Yes □ No

Note: A diagnosis of pulmonary hypertension is required for plan approval, excluding Adempas.

I attest the information on this form is accurate:

Physician Signature: _____ **Date:**_____

Product specific information Must also be completed:

If the request is for Adempas (riociguat):

1. Please select member's diagnosis

   ☐ Pulmonary hypertension Diagnosis code: _____

   ☐ Chronic thromboembolic pulmonary hypertension (CTEPH) Diagnosis code:_____

2. Member has had a negative pregnancy test in the past 30 days
   ☐ Yes ☐ No ☐ Not applicable to member
   Date of negative pregnancy test (include documentation): _____

3. Member is currently receiving one of the following: nitrate therapy, PDE5 inhibitor, nonspecific PDE inhibitor (dipyridamole; theophylline; aminophylline), vericiguat ☐ Yes ☐ No

4. Member is enrolled in the riociguat REMS program if meeting eligibility requirement
   ☐ Yes ☐ No ☐ Not applicable to member

5. Requested dose is 7.5mg per day or less ☐ Yes ☐ No
   If no, please explain:
   _____
   _____

If the request is for Adcirca (tadalafil):

1. Member is currently receiving one of the following: nitrate therapy, PDE-5 inhibitor (other than the one being requested), riociguat ☐ Yes ☐ No

2. Dose requested is 40 mg per day or less ☐ Yes ☐ No

3. Has there been a trial and failure of generic tadalafil or medical justification for why the generic medication cannot be used? ☐ Yes ☐ No
   If yes, please explain:
   _____
   _____

If the request is for Letairis (ambrisentan):

1. Member is enrolled in the ambrisentan or PS-ambrisentan REMS program if meeting eligibility requirement

   ☐ Yes ☐ No ☐ Not applicable to member

2. Member has had a negative pregnancy test in the past 30 days

   ☐ Yes ☐ No ☐ Not applicable to member

   Date of negative pregnancy test (include documentation): _____

3. **Note: dose of Letairis (ambrisentan) must be adjusted to max: 5 mg/day**

4. Member has had a previous trial and failure of Tracleer (bosentan) ☐ Yes ☐ No
   If no, please explain_____

. Dose requested is 10 mg per day or less ☐ Yes ☐ No

If the request is for Opsumit (macitentan):

1. Member is enrolled in the macitentan REMS program if meeting eligibility requirement
   ☐ Yes ☐ No ☐ Not applicable to member

2. Member has had a negative pregnancy test in the past 30 days
   ☐ Yes ☐ No ☐ Not applicable to member
   Date of negative pregnancy test (include documentation): _____

3. Member has had a previous trial and failure of Tracleer (bosentan) ☐ Yes ☐ No

   If no, please explain_____

4. Dose requested is 10 mg per day or less ☐ Yes ☐ No

If the request is for Orenitram (treprostinil):

1. Does the member have severe hepatic impairment (Child-Pugh class C)? ☐ Yes ☐ No

If the request is for Revatio (sildenafil) tablets or injection:

1. Member is currently receiving one of the following: nitrate therapy, riociguat, atazanavir, darunavir, fosamprenavir, indinavir, lopinavir/ritonavir, nelfinavir, ritonavir, saquinavir, tipranavir, PDE-5 inhibitor (other than the one being requested) ☐ Yes ☐ No

2. Dose requested is 60 mg per day or less ☐ Yes ☐ No

If the request is for Revatio (sildenafil) oral suspension:

1. Member is under 18 years of age ☐ Yes ☐ No

2. Member is unable to swallow tablet formulation ☐ Yes ☐ No

3. Member is currently receiving one of the following: nitrate therapy, riociguat, atazanavir, darunavir, fosamprenavir, indinavir, lopinavir/ritonavir, nelfinavir, ritonavir, saquinavir, tipranavir, PDE-5 inhibitor (other than the one being requested) ☐ Yes ☐ No

4. Dose requested is 60 mg per day or less ☐ Yes ☐ No
   Note: Revatio Suspension is brand preferred. If requesting sildenafil oral suspension, indicate the medically necessary reason for use:
   _____
   _____

If the request is for Tadliq (tadalafil) oral suspension:

1. Member is under 18 years of age ☐ Yes ☐ No

2. Member is unable to swallow tablet formulation ☐ Yes ☐ No

3. Member is currently receiving one of the following: nitrate therapy, PDE-5 inhibitor (other than the one being requested), riociguat ☐ Yes ☐ No

4. Dose requested is 40 mg per day or less ☐ Yes ☐ No

5. Member has had a previous trial and failure of Revatio (sildenafil) oral suspension ☐ Yes ☐ No
   If no, please explain:
   _____
   _____

If the request is for Uptravi (selexipag):

1. Member has had a previous trial and failure of Orenitram (treprostinil) ☐ Yes ☐ No

   If no, please explain_____

2. Will the member be utilizing a CYP2C8 inhibitor (e.g., gemfibrozil) concurrently with selexipag?
   ☐ Yes ☐ No

If the request is for Tracleer (bosentan):

Request is for:

- ☐ Tracleer tablet
- ☐ Tracleer dispersible tablet
- ☐ Bosentan tablet*

1. Member is enrolled in the bosentan REMS program (***Note**: ALL members **must** be enrolled in the bosentan REMS program)* ☐ Yes ☐ No

2. Member has had a negative pregnancy test in the past 30 days
   ☐ Yes ☐ No ☐ Not applicable to member
   Date of negative pregnancy test (include documentation): _____

3. Will the member be utilizing cyclosporine-A or glyburide therapy concurrently with bosentan?
   ☐ Yes ☐ No

4. Member age: _____ weight: _____ LB/KG (circle one)

5. Does the requested dose exceed 250mg per day OR dose limits based on age/weight listed in criteria? ☐ Yes ☐ No
   If yes, please explain:
   _____
   _____