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 Indiana License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Office Contact
Prescriber Fax ☐☐☐ - ☐☐☐ - ☐☐☐☐	Prescriber Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐
Prescriber Address	Date(s) of Service: _____ Start Date: _____
Diagnosis:	Diagnosis Code:

Requested Medication	Strength	Quantity	Directions for Use

General information applicable to all products:

Pulmonary Antihypertensive PA Requirements for ALL agents:

1. Does the member have a diagnosis of pulmonary hypertension? ☐ Yes ☐ No
2. Does the member have a diagnosis of pulmonary hypertension associated with interstitial lung disease (only applicable to Tyvaso/Tyvaso DPI)? ☐ Yes ☐ No
3. Does the member have a diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH) (only applicable to Adempas)? ☐ Yes ☐ No
4. Is the requested agent prescribed by, or in consultation with, a pulmonologist or cardiologist?
   ☐ Yes ☐ No

Product specific information:

If the request is for Adempas (riociguat):

1. For those of childbearing potential, has a negative pregnancy test been obtained and submitted in the past 30 days? □ Yes □ No □ Not applicable to member

   Date of negative pregnancy test (include documentation): _____

2. Is the member currently receiving one of the following: nitrate therapy, PDE5 inhibitor, nonspecific PDE inhibitor (dipyridamole; theophylline; aminophylline), or vericiguat? □ Yes □ No

3. For those who meet the eligibility requirement, are they enrolled in the riociguat REMS program? □ Yes □ No □ Not applicable to member

4. Is the member's requested dose 7.5 mg per day or less? □ Yes □ No

   If no, please explain:

   _____

If the request is for Adcirca (tadalafil):

1. Is the member currently receiving one of the following: nitrate therapy, PDE-5 inhibitor (other than the one being requested), or riociguat? □ Yes □ No

2. Is the dose requested 40 mg per day or less? □ Yes □ No

   Note: 'Alyq' requires trial and failure of generic tadalafil or medical justification for use.

If the request is for Letairis (ambrisentan):

1. For members who meet the eligibility requirement, are they enrolled in the ambrisentan or PS-ambrisentan REMS program? □ Yes □ No □ Not applicable to member

2. For those of childbearing potential, has a negative pregnancy test been obtained and submitted in the past 30 days? □ Yes □ No □ Not applicable to member

   Date of negative pregnancy test (include documentation): _____

3. Is the member currently receiving cyclosporine therapy (requires dose reduction)? □ Yes □ No

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

4. Has the member had a previous trial and failure of Tracleer (bosentan)? □ Yes □ No

   If no, please explain:

   _____

5. Is the dose requested 10 mg per day or less? □ Yes □ No

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

1. Is the member 18 years of age or older? □ Yes □ No

2. Is the member unable to swallow tablet formulation? □ Yes □ No

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

4. Is the dose requested 60 mg per day or less? □ Yes □ No

5. Has the member had a previous trial and failure of Revatio (sildenafil) suspension? □ Yes □ No
   If no, please explain:
   _____

If the request is for Opsumit (macitentan):

1. For those who meet the eligibility requirement, are they enrolled in the macitentan REMS program? □ Yes □ No □ Not applicable to member
2. For those of childbearing potential, has a negative pregnancy test been obtained and submitted in the past 30 days? □ Yes □ No □ Not applicable to member
   Date of negative pregnancy test (include documentation): _____
3. Has the member had a previous trial and failure of Tracleer (bosentan)? □ Yes □ No
   If no, please explain:
   _____
4. Is the dose requested 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
   Note: Members with Child-Pugh class C hepatic impairment will be denied; Orenitram titration packs will be limited to 1 pack per 90 days.

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

1. Is the member currently receiving one of the following: nitrate therapy, riociguat, atazanavir, darunavir, fosamprenavir, indinavir, lopinavir/ritonavir, nelfinavir, ritonavir, saquinavir, tipranavir, or PDE-5 inhibitor (other than the one being requested)? □ Yes □ No
2. Is the requested dose 60 mg per day or less? □ Yes □ No

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

1. Is the member under 12 years of age? □ Yes □ No
2. Is the member unable to swallow a tablet formulation? □ Yes □ No
3. Is the member currently receiving one of the following: nitrate therapy, riociguat, atazanavir, darunavir, fosamprenavir, indinavir, lopinavir/ritonavir, nelfinavir, ritonavir, saquinavir, tipranavir, or PDE-5 inhibitor (other than the one being requested)? □ Yes □ No
4. Is the dose requested 60 mg per day or less? □ Yes □ No

   Note: Revatio Suspension is brand preferred. Authorization for generic sildenafil oral suspension is contingent upon medical necessity for use instead of the branded agent.

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

1. Is the member under 12 years of age? □ Yes □ No
2. Is the member unable to swallow a tablet formulation? □ Yes □ No
3. Is the member currently receiving one of the following: nitrate therapy, PDE-5 inhibitor (other than the one being requested), or riociguat? □ Yes □ No
4. Is the dose 40 mg per day or less? □ Yes □ No

5. Has the member 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. Has the member 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

Note: Members planning to use CYP2C8 inhibitors concurrently with selexipag will be denied.

If the request is for Tracleer (bosentan):

Request is for:

□ Tracleer tablet
□ Tracleer dispersible tablet
□ bosentan tablet*

1. Is the member enrolled in the bosentan REMS program? □ Yes □ No
Note: ALL members must be enrolled in the bosentan REMS program.

2. For those of childbearing potential, has a negative pregnancy test been obtained and submitted 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

Note: Members planning to use cyclosporine-A or glyburide concurrently with bosentan will be denied.

4. Member Age: _____ Member Weight: _____ LB/KG (circle one)

5. Does the requested dose exceed 250 mg per day OR are the dose limits based on age/weight listed in criteria? □ Yes □ No

If yes, please explain:

_____

Note: Tracleer tablets are brand preferred. Authorization for generic bosentan tablets is contingent upon medical necessity for use instead of the branded agent.