PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Adempas (riociguat)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. What are the quantity and days supply requested? Note: quantity will be limited to a 14-day supply during titration period.

Q2. For what diagnosis is this drug being prescribed (pick one)?

- ☐ Chronic thromboembolic pulmonary hypertension (CTEPH) WHO group 4
- ☐ Pulmonary arterial hypertension (PAH) WHO Group 1
- ☐ Other (please specify)

Q3. Please provide the ICD diagnosis code for the condition listed above.

Q4. Is the patient a new start to therapy?

☐ Yes ☐ No - please specify start date

Q5. Specify the prescriber's specialty

☐ Cardiologist ☐ Pulmonologist ☐ Other

Q6. If for PAH, was it confirmed by right heart catheterization?

Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Adempas (riociguat)

Phone: 800-728-7947 **Fax back to: 866-880-4532**

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**

☐ Yes ☐ No

Q7. If for CTEPH, does the patient have the following? Please select all that apply:

☐ Recurrent or persistent CTEPH after pulmonary endarterectomy (PEA)
☐ Inoperable CTEPH confirmed by perfusion scanning or pulmonary angiography
☐ Inoperable CTEPH confirmed by pretreatment right heart catheterization with mean pulmonary artery pressure (mPAP) > 25 mmHg, pulmonary capillary wedge pressure (PCWP) < 15 mmHg, and pulmonary vascular resistance (PVR) > 3 Wood units

Q8. Will the patient be taking any of the following concomitantly with Adempas? Please select all that apply:

☐ Nitrates or nitric oxide donors
☐ Specific or non-specific phosphodiesterase-5 (PDE5) inhibitors
☐ Theophylline derivatives
☐ None of the above

Q9. Is the patient a smoker?

☐ Yes ☐ No

Q10. If the patient is female, is she currently enrolled in the Adempas REMS program?

☐ Yes
☐ No
☐ Not applicable - patient is male

Q11. Please select all that apply regarding child-bearing potential:

☐ Pregnancy has been excluded prior to treatment initiation
☐ Pregnancy tests to exclude pregnancy will be conducted monthly during treatment and for 1 month after treatment discontinuation
☐ Patient will use effective forms of contraception to prevent pregnancy during treatment and for one month after treatment discontinuation
☐ Patient is male
☐ Patient is female but does not have child-bearing potential

Q12. Does the patient have failure of an adequate trial of, contraindication, intolerance to, or persistence of symptoms with the following? Please select all that apply:

☐ Calcium channel blocker (if WHO Group 1 and positive vasoreactivity test)
☐ Sildenafil

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Adempas (riociguat)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**

☐ Letairis or Tracleer
☐ Other (please specify)

Q13. If for continuation, please select all the following that apply:

☐ Patient is tolerating treatment
☐ Patient has evidence of continued disease stabilization or improvement
☐ Patient has continued medical need for Adempas

Q14. Additional Comments:

Prescriber Signature _____ Date _____

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.