Please Note: Medical Necessity Prior Authorization may be overrided for both formulary coverage and benefit design restrictions. They are issued at the full discretion of the benefit manager.

PRIOR AUTHORIZATION BYPASS
Adempas® (riociguat)

Bypass the Prior Authorization by Modifying the following Prescription Forms to the Patient's needs

Name ____________________

Address ____________________

℞

COMPLETE PRIOR AUTHORIZATION FORMS

Dx PULMONARY HYPERTENSION

ICD10: I 27.2

MD ____________________

Signature ____________________

Name ____________________

Address ____________________

℞

MD ____________________

Signature ____________________

SAMPLE

Prescriber Information

Last Name:	First Name
DEA/NPI:	Specialty:
Phone: _ _ _ - _ _ _ - _ _ _ _	Fax: _ _ _ - _ _ _ - _ _ _ _

Member Information

Last Name:	First Name
Member ID Number	DOB: _ _ - _ _ - _ _ _ _

Medication Information:

Drug Name and Strength: ______________________	Quantity and Dosing: ______________________
Diagnosis: ______________________	Duration: ______________________

When advised below, please include all requested fax documentation (lab results, etc.) when submitting this Prior Authorization fax form; not submitting requested documentation could delay the clinical review process.

Adempas Prior Authorization Form

You must answer ALL of the following questions		
1. Does the patient have one of the following diagnoses? **(Please Circle)** • Pulmonary Arterial Hypertension • Chronic Thromboembolic Pulmonary Hypertension (CTEPH) • Other: ______________________	Y	N
PULMONARY ARTERIAL HYPERTENSION (PAH)		
2. Is the prescribing physician a specialist in one of the following fields: pulmonology, cardiology, nephrology, or rheumatology?	Y	N
3. Is the patient 18 years of age or older?	Y	N
4. Does the patient have a diagnosis of Group 1 PAH as defined by one of the following etiologies? *Please provide documentation.* • Idiopathic / primary (PAH) • Drugs and toxins induced • Tissue disease (e.g., Lupus/SLE, RA scleroderma, systemic sclerosis, CREST syndrome, polymyositis, polyarteritis nodosa, mixed connective tissue disease) • HIV infection • Portal hypertension • Congenital heart disease • Schistosomiasis • Chronic hemolytic anemia	Y	N

Contact Information:

Telephone: (855)251.9116
Fax: (248)593.9575

Please Note: Medical Necessity Prior Authorization may be utilized to override both formulary coverage and benefit design restrictions. They are issued at the full discretion of the benefit manager.

PRIOR AUTHORIZATION FORM: COVER PAGE

MEMBER INFORMATION			
First Name		**Last Name**	
Plan			
Member ID		**Date of Birth**	
DRUG INFORMATION			
Drug Name			
Quantity		**ICD-10**	
Directions		**Duration of Therapy**	
Diagnosis			
PLEASE LIST ALTERNATIVE THERAPIES THAT HAVE BEEN ATTEMPTED AND ANY OTHER PERTINENT INFORMATION RELATED TO DRUG AND/OR DISEASE STATE. IF NOT PRESENT, WITHIN NORMAL LIMITS WILL BE USED FOR THE REVIEW.			
Medication/Failure Reason:			

IgE:_______________

ESR:________________ **CRP:**________________ **# Joints:**________________ **%BSA:**_______________

Height:________________ **Weight:**________________ **BMI:**________________

HA1C:________________ **Hemoglobin:**________________ **Hematocrit:**________________ **T-Score:**______________

Dialysis:______________ **Long Term Care Facility:**______________ **Self Injecting:**______________

Stimulation test:__________/__________ **Growth velocity:**___________ **#Chemotherapy cycles/month:**__________

Mini-Mental Status Test:_____________ **Baseline Free testosterone/Total testosterone:**__________/_________

HCV RNA viral load:_______________ **Viral Genotype:**________________ **ALT:**________________

PHYSICIAN INFORMATION			
Physician Signature		**Date**	
Physician Name		**NPI #**	
Phone Number		**Fax Number**	
Action Needed	Only mark Urgent when standard review time would seriously harm the member's life or health or ability to regain maximum function ☐ Urgent ☐ For Review	**Pharmacy Fax**	

The information contained in this facsimile message, including the attachments, may be privileged, may constitute inside information and is intended only for use of the addressee. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited and may be unlawful. If you have received this communication in error, please immediately notify me by replying to this message and destroy the original message.