Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

PAH Agents (FA-PA)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-855-240-0536** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of PAH Agents (FA-PA).

Drug Name (select from list of drugs shown)
Opsumit (macitentan)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. The preferred products for your patient's plan are Letairis (ambrisentan) and Tracleer (bosentan). Can the patient's treatment be switched to any of the preferred products?	Y N
2. Is the patient currently receiving Opsumit through health insurance?	Y N
Note: If the patient is receiving Opsumit through samples or a manufacturer's patient assistance program, please answer No.	
3. Has the patient tried and experienced an inadequate response to Letairis or Tracleer?	Y N

4.	Has the patient tried and experienced an intolerable adverse event to Letairis or Tracleer or any of their components?	Y N
5.	Does the patient have a documented contraindication to Letairis or Tracleer or any of their components?	Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date