PRIOR AUTHORIZATION REQUEST
Orenitram

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. What is the indication or diagnosis?
   - ☐ Pulmonary arterial hypertension (PAH) World Health Organization (WHO) Group 1
   - ☐ All other indications – (Please Specify) _____
2. ☐ Yes ☐ No Does the patient have WHO Group 1 PAH?
3. ☐ Yes ☐ No Is the medication being prescribed by, or in consultation with, a cardiologist or a pulmonologist?
4. ☐ Yes ☐ No Is the patient currently receiving the requested medication?
5. ☐ Yes ☐ No Is documentation being provided to confirm that the patient has had a right heart catheterization?
6. ☐ Yes ☐ No Did the results of the right heart catheterization confirm the diagnosis of WHO Group 1 PAH?
7. ☐ Yes ☐ No Has the patient had a right heart catheterization?
8. ☐ Yes ☐ No Has the patient tried TWO oral therapies for PAH (or is currently receiving them) from two of the three following different categories (either alone or in combination) each for greater than or equal to 60 days: one phosphodiesterase type 5 (PDE5) inhibitor, one endothelin receptor antagonist (ERA), or Adempas (riociguat tablets)?
9. ☐ Yes ☐ No Is the patient receiving, or has received in the past, one prostacyclin therapy for PAH or a prostacyclin receptor agonist (for example, Uptravi) for PAH?

Please document the diagnoses, symptoms, and/or any other information important to this review:

_____

_____

If you have any questions, call: 800-753-2851

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SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

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If you have any questions, call: 800-753-2851