PRIOR AUTHORIZATION REQUEST

ORENITRAM

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 Is this request for INITIAL or for CONTINUATION of therapy?

[] Initial (If checked, go to 7)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 7.]

If you have any questions, call: 1-888-258-8250

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3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	What is the diagnosis or indication? [] Pulmonary arterial hypertension (PAH) World Health Organization (WHO) Group 1 (If checked, go to 8) [] Other (If checked, no further questions)		
8	Is documentation provided to confirm that the patient has had a right heart catheterization? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
9	Did the results of the right heart catheterization confirm the diagnosis of WHO Group 1 PAH? [If no, no further questions.]	Yes	No
10	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: A) One phosphodiesterase type 5 (PDE5) inhibitor, B) One endothelin receptor antagonist (ERA), or C) Adempas (riociguat tablets)? ACTION REQUIRED: Submit supporting documentation. [NOTE: Examples of PDE5 inhibitors include Revatio (sildenafil tablets and suspension), Adcirca (tadalafil tablets), and Alyq (tadalafil tablets), and examples of ERAs include Tracleer (bosentan tablets), Letairis (ambrisentan tablets [generic]), and Opsumit (macitentan tablets).] [If yes, skip to question 12.]	Yes	No
11	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 intolerance or contraindication to prostacyclin therapy? ACTION REQUIRED: Submit supporting documentation.	Yes	No

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	[NOTE: Examples of prostacyclin therapies for PAH include Tyvaso (treprostinil inhalation solution), Ventavis (iloprost inhalation solution), Remodulin (treprostinil injection), and epoprostenol injection (Flolan, Veletri).] [If no, no further questions.]		
12	Is the medication being prescribed by, or in consultation with, a cardiologist or a pulmonologist? [If no, no further questions.]	Yes	No
13	Does the requested dose exceed FDA approved label dosing for the requested indication? Note: Maximum daily dose of 120 mg.	Yes	No

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

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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