

Ticket #: _____ Request Date: _____ Request Time: _____

Adempas® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below: <input type="checkbox"/> Chronic thromboembolic pulmonary hypertension (CTEPH) <input type="checkbox"/> Pulmonary arterial hypertension (PAH) <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Provider's Specialty: Is the requested medication prescribed by or in consultation with a pulmonologist or cardiologist? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For chronic thromboembolic pulmonary hypertension (CTEPH), answer the following: Does the patient have inoperable or persistent/recurrent CTEPH? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have CTEPH that is symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient currently on any therapy for the diagnosis of CTEPH? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For pulmonary arterial hypertension (PAH), answer the following: Does the patient have PAH that is symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No Was the diagnosis of PAH confirmed by right heart catheterization? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient currently on any therapy for the diagnosis of PAH? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Reauthorization: If this is a reauthorization request, answer the following question: Is there documentation the patient has had a positive clinical response to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Quantity Limit Requests: What is the quantity requested per DAY? _____ What is the reason for exceeding the plan limitations? <input type="checkbox"/> Titration or loading dose purposes <input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime) <input type="checkbox"/> Requested strength/dose is not commercially available <input type="checkbox"/> Other: _____					

Please note that this form is to be completed by the prescribing physician. This document and others, if attached, contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. If you are not the intended recipient, please notify the sender immediately.
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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Authorized Medical Signature:	
Telephone:	Date:

When Completed Return To:

ProCare PBM Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

Please note: This request may be denied unless all required information is received.

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