MC-Rx
Powered by ProCare Rx

Adempas®

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

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

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Chronic thromboembolic pulmonary hypertension (CTEPH)
❑ Pulmonary arterial hypertension (PAH)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Provider's Specialty:

Is the requested medication prescribed by or in consultation with a pulmonologist or cardiologist? ❑ **Yes** ❑ **No**

For chronic thromboembolic pulmonary hypertension (CTEPH), answer the following:

Does the patient have inoperable or persistent/recurrent CTEPH? ❑ **Yes** ❑ **No**
Does the patient have CTEPH that is symptomatic? ❑ **Yes** ❑ **No**
Is the patient currently on any therapy for the diagnosis of CTEPH? ❑ **Yes** ❑ **No**

For pulmonary arterial hypertension (PAH), answer the following:

Does the patient have PAH that is symptomatic? ❑ **Yes** ❑ **No**
Was the diagnosis of PAH confirmed by right heart catheterization? ❑ **Yes** ❑ **No**
Is the patient currently on any therapy for the diagnosis of PAH? ❑ **Yes** ❑ **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? ❑ **Yes** ❑ **No**

Quantity Limit Requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes
❑ 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)
❑ Requested strength/dose is not commercially available
❑ Other:

_____

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

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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:

MC-Rx 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.