Adempas® (riociguat)

PRIOR AUTHORIZATION REQUEST FORM

For authorization, **please answer each question, include patient chart notes to document clinical information, and fax this form back to the PEHP Prior Authorization Department at (801) 245-7774** or mail to: PEHP Pharmacy services, 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization questions, you may phone the PEHP Customer Service at (801) 366-7551.

1. Date:	2. Patient Name:	3. ID #:
4. D.O.B:	5. Physician:	6. Office Phone:
7. Office Fax:	8. Office Contact:	9. Dose Request:
10. Sex:	11. Weight:	

Authorization is requested from: to

Not to exceed 6 months for initial therapy. Additional therapy may be approved for up to 2 years.

Question	Yes	No	Comments/Notes
12. Is the prescribing provider a pulmonologist, cardiologist, or obtained a consult from one of the listed specialty?			
13. If the patient is female and of childbearing years, she is NOT pregnant, has NO plans for pregnancy, or has been educated on the potential dangers of Adempas® therapy?			
14. Is the patient's diagnosis due to previous use of fenfluramine and phentermine?			
15. If 'yes' to 14, indicate time of use. Dates:			
16. Is the diagnosis documented as treatment of Pulmonary Arterial Hypertension WHO Group 1 or Group 4?			
17. Has the diagnosis been confirmed by right heart catheterization?			
18. Are the patients mean pulmonary arterial pressure (mPAP) > 25mmHg at rest, and the pulmonary capillary wedge pressure < 15mmHG, and the pulmonary vascular resistance > 3 Wood units (240 dyn*sec/cm5)?			
19. If the diagnosis is documented as PAH (WHO group 1), are the patients functional class symptoms documented as WHO class II or III?			
20. If 'yes' to 19, has the patient had an adequate trial and failure (4 weeks or more) to a calcium channel blocker?			Verification will be made by reviewing the patient's drug history or patient chart notes.
21. If 'no' to 20, is the patient not a candidate for calcium channel blocker therapy: (1) Patient did not respond to a vasodilator challenge with greater than 20% reduction in mean pulmonary artery pressure, (2) has depressed cardiac output, (3) has systemic hypotension?			
22. If the diagnosis is PAH (WHO group 1), has the patient had a trial and failure to 2 of the following medication classes: PDE5 inhibitors, ERA, Inhaled prostacyclin?			
23. If the diagnosis is CTEPH (WHO group 4), has the diagnosis been confirmed by at least 2 of the following imaging methods: Ventilation-perfusion scanning, pulmonary angiography, spiral CT, magnetic resonance angiography?			
24. If 'yes' to 22, is the patient not eligible for pulmonary endarterectomy or does the patient have recurrent disease following surgery?			Provide documentation of surgery consult.
25. Has the patient received previous Adempas® therapy?			
26. If 'yes' to 24, has the patient seen an improvement in their exercise ability (walking distance), dyspnea, fatigue, and/or no clinical worsening of pulmonary hypertension?			Documentation is required.

27. Physician's Signature: _____