Tracleer, bosentan

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: _____**Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What drug is being prescribed?
   ❑ Tracleer 32 mg ❑ Tracleer 62.5 mg ❑ Tracleer 125 mg
   ❑ bosentan 62.5 mg ❑ bosentan 125 mg

2. What is the diagnosis?
   ❑ Pulmonary arterial hypertension (PAH) (includes Eisenmenger's syndrome)
   ❑ Other _____

3. What is the ICD-10 code? _____

Complete the following questions if Tracleer is being prescribed. If bosentan is being prescribed, skip to #11.

4. Is the product being requested for the treatment of pulmonary arterial hypertension (PAH) WHO Group 1?
   ❑ Yes ❑ No *If No, skip to #11*

5. The preferred products for your patient's health plan are ambrisentan, bosentan, and Opsumit. Can the patient's treatment be switched to a preferred product? ***If switched to ambrisentan or Opsumit, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.***
   ❑ Yes - ambrisentan
   ❑ Yes - bosentan, *fax a new prescription to the pharmacy and skip to #11.*
   ❑ Yes - Opsumit
   ❑ No - Continue request for Tracleer

6. Does the patient have a documented intolerable adverse event to the preferred product bosentan?
   ACTION REQUIRED: If 'Yes', attach supporting chart note(s). ❑ Yes ❑ No

7. Was the documented intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information? ***ACTION REQUIRED: If 'No', attach supporting chart note(s).***
   ❑ Yes ❑ No

8. Is the request for a pediatric patient? ❑ Yes ❑ No *If No, skip to #10*

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

 Tracleer [bosentan] ACSF SGM - 5/2023.

9. Does the patient require the 32 mg tablets for oral suspension? *If Yes, skip to #11* ❑ Yes ❑ No

10. Does the patient have a documented inadequate response, intolerable adverse event, or contraindication to treatment with any of the preferred products, ambrisentan and Opsumit? ***ACTION REQUIRED: If 'Yes', attach supporting chart note(s).***
    - ❑ bosentan: ❑ Intolerable adverse event ❑ Inadequate response ❑ Contraindication
    - ❑ ambrisentan: ❑ Intolerable adverse event ❑ Inadequate response ❑ Contraindication
    - ❑ Opsumit: ❑ Intolerable adverse event ❑ Inadequate response ❑ Contraindication

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

12. Is the patient currently receiving treatment with the requested medication? ❑ Yes ❑ No *If No, skip to #15*

13. Is the patient currently receiving the requested medication through a paid pharmacy or medical benefit?
    ❑ Yes ❑ No ❑ Unknown *If No or Unknown, skip to #15*

14. Is the patient experiencing a benefit from therapy with the requested medication as evidenced by disease stability or disease improvement? ❑ Yes ❑ No *No further questions.*

15. What is the World Health Organization (WHO) classification of pulmonary hypertension?
    - ❑ **WHO Group 1** (Pulmonary arterial hypertension)
    - ❑ **WHO Group 2** (Pulmonary hypertension owing to left heart disease)
    - ❑ **WHO Group 3** (Pulmonary hypertension owing to lung disease and/or hypoxia)
    - ❑ **WHO Group 4** (Chronic thromboembolic pulmonary hypertension)
    - ❑ **WHO Group 5** (Pulmonary hypertension with unclear multifactorial mechanisms)

16. Has the diagnosis been confirmed by right heart catheterization? ❑ Yes ❑ No *If No, skip to #20*

17. What is the pretreatment mean pulmonary arterial pressure (mPAP) at rest? _____ mmHg

18. What is the pretreatment pulmonary capillary wedge pressure (PCWP)? _____ mmHg

19. What is the pretreatment pulmonary vascular resistance (PVR)? _____ Wood units *No further questions.*

20. Is the patient an infant less than one year of age? ❑ Yes ❑ No

21. Has Doppler echocardiogram been performed to confirm the diagnosis? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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