

Pre - PA Allowance

None

Prior-Approval Requirements

Age 18 years of age or older

Diagnosis

Patient must have the following:

1. Pulmonary Arterial Hypertension (PAH) - **WHO Group I**
 - a. NYHA functional classification of physical activity – **Class II or III**
 - b. Absence of clinically significant anemia
 - c. Prescribed by or recommended by a cardiologist or pulmonologist
 - d. Females of reproductive potential should have pregnancy excluded and agree to use acceptable method of contraception during therapy and for one month after stopping therapy
 - e. Absence of a concurrent diagnosis of Idiopathic Pulmonary Fibrosis (IPF)
 - f. Prescriber agrees to monitor for pulmonary edema and discontinue if confirmed
 - g. **Brand Letairis only:** Patient **MUST** have tried the preferred product (generic Letairis: ambrisentan) unless the patient has a valid medical exception (e.g., inadequate treatment response, intolerance, contraindication)

Prior - Approval Limits

Quantity 90 tablets per 90 days

Duration 2 years

Prior – Approval *Renewal* Requirements

Age 18 years of age or older

Diagnosis

Patient must have the following:



**BlueCross
BlueShield**

Federal Employee Program

**LETAIRIS
(ambrisentan)**

1. Pulmonary Arterial Hypertension (PAH) - WHO Group I
 - a. Symptoms have improved or stabilized
 - b. Females of reproductive potential should have pregnancy excluded and agree to use acceptable method of contraception during therapy and for one month after stopping therapy
 - c. Absence of a concurrent diagnosis of Idiopathic Pulmonary Fibrosis (IPF)
 - d. Prescriber agrees to monitor for pulmonary edema and discontinue if confirmed
 - e. **Brand Letairis only:** Patient **MUST** have tried the preferred product (generic Letairis: ambrisentan) unless the patient has a valid medical exception (e.g. inadequate treatment response, intolerance, contraindication)

Prior – Approval *Renewal* Limits

Same as above