BlueCross BlueShield
Federal Employee Program

ADEMPAS
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Adempas (riociguat)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on Adempas continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGES 3 and 4**
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. What is the patient's diagnosis?
   ❑Chronic Thromboembolic Pulmonary Hypertension (CTEPH) (WHO Group 4)
   a. Is the patient's chronic thromboembolic pulmonary hypertension persistent/recurrent? ❑Yes ❑No
   b. Has the patient had prior surgical treatment OR was the CTEPH deemed inoperable? ❑Yes ❑No

   ❑Pulmonary Arterial Hypertension (PAH) (WHO Group 1)

   ❑Pulmonary hypertension
   a. What is the cause of the pulmonary hypertension? ***Please select answer below:***

   ❑Congenital heart disease (WHO Group 1)
   ❑Connective tissue disease (WHO Group 1)
   ❑Drugs or toxins induced (WHO Group 1)
   ❑Heritable PAH (WHO Group 1)
   ❑HIV infection (WHO Group 1)
   ❑Idiopathic/**Unknown** cause (WHO Group 1)
   ❑Portal hypertension (WHO Group 1)
   ❑Schistosomiasis (WHO Group 1)
   ❑Persistent pulmonary hypertension of the newborn (PPHN) (WHO Group 1)
   ❑Pulmonary capillary hemangiomatosis (PCH) (WHO Group 1)
   ❑Pulmonary veno-occlusive disease (PVOD) (WHO Group 1)
   ❑Left heart disease (WHO Group 2)
   ❑Lung disease or hypoxemia (WHO Group 3)
   ❑Chronic thrombotic or embolic disease (CTEPH) (WHO Group 4)
   ❑Unclear multifactorial mechanisms (WHO Group 5)
   ❑Other cause ***(please specify)***: _____

   ❑Other diagnosis ***(please specify):*** _____
4. What level of activity causes the patient to experience shortness of breath or fatigue? ***Please select answer below:***
   ❑No symptoms and no limitations in ordinary physical activity (Class I)
   ❑Mild symptoms and slight limitation during ordinary activity (Class II)
   ❑Marked limitation in activity due to symptoms, even during less than ordinary activity (Class III)
   ❑Experience shortness of breath and fatigue while at rest (Class IV)
5. Has Adempas been prescribed by or recommended by either a cardiologist or pulmonologist? ❑Yes ❑No
6. Does the prescriber agree to monitor for pulmonary edema and discontinue Adempas if confirmed? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL INITIATION QUESTIONS

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ **DOB:** _____ **Patient ID: R** _____

7. **FEMALE Patient**: Please answer the following questions:
   a. Are the patient and prescriber enrolled in the Adempas REMS program? ❑Yes ❑No
   b. Is the patient of reproductive potential? ❑Yes***** ***(If YES, please answer the following questions)*** ❑No
      i. Will pregnancy be excluded before the start of treatment? ❑Yes ❑No
      ii. Will the patient be advised to use effective contraception during treatment with Adempas and for one month after the last dose? ❑Yes ❑No

8. Will Adempas be used in combination with any nitrates in any form? ❑Yes***** ❑No
   ****If YES***, specify medication: _____
   ****Examples include isosorbide dinitrate (Isordil), isosorbide mononitrate (Imdur, Ismo), nitroglycerin tablets, capsules, or patches (Nitro-Dur), and isosorbide dinitrate/hydralazine (BiDil).***

9. Will Adempas be used in combination with nitric oxide donors? ❑Yes***** ❑No
   ****If YES***, specify medication: _____
   ****Examples include amyl nitrate.***

10. Will Adempas be used in combination with any phosphodiesterase-5 (PDE-5) inhibitors? ❑Yes***** ❑No
    ****If YES***, specify medication: _____
    ****Examples include Viagra/Revatio (sildenafil), Cialis/Adcirca (tadalafil), Levitra/Staxyn (vardenafil), and Stendra (avanafil).***

11. Will Adempas be used in combination with other soluble guanylate cyclase (sGC) stimulators, such as Verquvo (vericiguat)? ❑Yes***** ❑No
    ****If YES***, specify medication: _____

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Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

CONTINUATION OF THERAPY (PA RENEWAL)

Adempas (riociguat)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on Adempas continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGES 1 and 2**
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. What is the patient's diagnosis?
   ❑Chronic Thromboembolic Pulmonary Hypertension (CTEPH) (WHO Group 4)
   ❑Pulmonary Arterial Hypertension (PAH) (WHO Group 1)
   ❑Pulmonary hypertension
   a. What is the cause of the pulmonary hypertension? ***Please select answer below:***
      - ❑Congenital heart disease (WHO Group 1)
      - ❑Connective tissue disease (WHO Group 1)
      - ❑Drugs or toxins induced (WHO Group 1)
      - ❑Heritable PAH (WHO Group 1)
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      - ❑Pulmonary veno-occlusive disease (PVOD) (WHO Group 1)
      - ❑Left heart disease (WHO Group 2)
      - ❑Lung disease or hypoxemia (WHO Group 3)
      - ❑Chronic thrombotic or embolic disease (CTEPH) (WHO Group 4)
      - ❑Unclear multifactorial mechanisms (WHO Group 5)
      - ❑Other cause ***(please specify)***: _____
   ❑Other diagnosis ***(please specify):*** _____
4. Have the patient's condition improved or stabilized with therapy? ❑Yes ❑No
5. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes***** ❑No
   If YES, will the patient be advised to use effective contraception during treatment with Adempas and for one month after the last dose? ❑Yes ❑No
6. Does the prescriber agree to monitor for pulmonary edema and discontinue Adempas if confirmed? ❑Yes ❑No
7. Will Adempas be used in combination with any nitrates in any form? ❑Yes***** ❑No
   If YES, specify medication: _____
   Examples include isosorbide dinitrate (Isordil), isosorbide mononitrate (Imdur, Ismo), nitroglycerin tablets, capsules, or patches (Nitro-Dur), and isosorbide dinitrate/hydralazine (BiDil).

PLEASE PROCEED TO PAGE 4 FOR ADDITIONAL CONTINUATION QUESTIONS

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Patient Name: _____ DOB: _____ Patient ID: R _____

8. Will Adempas be used in combination with nitric oxide donors? ❑Yes* ❑No
   If YES, specify medication: _____
   Examples include amyl nitrate.

9. Will Adempas be used in combination with any phosphodiesterase-5 (PDE-5) inhibitors? ❑Yes* ❑No
   If YES, specify medication: _____
   Examples include Viagra/Revatio (sildenafil), Cialis/Adcirca (tadalafil), Levitra/Staxyn (vardenafil), and Stendra (avanafil).

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    If YES, specify medication: _____

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***