BlueCross BlueShield Federal Employee Program

LETAIRIS
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

For Standard Option patients GENERIC Letairis (ambrisentan) is the preferred product. Please consider prescribing the preferred product. Standard Option patients who switch to generic Letairis will be eligible for 2 copays at no cost in the benefit year.

Letairis (ambrisentan)

****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

Is this request for brand or generic? ❑Brand ❑Generic

Will the patient need more than 90 tablets every 90 days? ❑Yes* ❑No

If YES, please specify the requested quantity: _____ tablets every 90 days

BRAND Letairis Request (Standard Option Patient): Would you like to switch the patient to the preferred product generic Letairis (ambrisentan)? ❑Yes, switch to generic Letairis (ambrisentan) ❑No, do not switch*

If NO, does the patient have an intolerance or contraindication to or have they had an inadequate treatment response to the preferred medication generic Letairis (ambrisentan)? ❑Yes ❑No*

If NO, is there a clinical reason for not trying the preferred medication generic Letairis (ambrisentan)? ❑Yes ❑No

GENERIC Letairis (ambrisentan) Request (Standard Option Patient): Is generic Letairis (ambrisentan) being requested as a change from **BRAND** Letairis to allow the member access to their copay benefit? ❑Yes ❑No

1. What is the patient's diagnosis?

❑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)
❑Pulmonary veno-occlusive disease (PVOD) (WHO Group 1)
❑Pulmonary capillary hemangiomatosis (PCH) (WHO Group 1)
❑Persistent pulmonary hypertension of the newborn (PPHN) (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):*** _____

2. Does the prescriber agree to monitor the patient for pulmonary edema and to discontinue therapy if confirmed? ❑Yes ❑No

3. Does the patient have a concurrent diagnosis of Idiopathic Pulmonary Fibrosis (IPF)? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS

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PAGE 2 - PHYSICIAN COMPLETES

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

4. Has the patient been on this medication continuously for the last **6 months**, excluding samples? ***Select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

a. Which level of physical 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)

❑Experiences shortness of breath and fatigue while at rest (Class IV)

b. Does the patient have clinically significant anemia? ❑Yes ❑No

c. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes***** ***(*If YES, please answer questions 1 and 2 below)*** ❑No

1) Will pregnancy be excluded before the start of treatment with Letairis? ❑Yes ❑No

2) Will the patient be advised to use an acceptable method of contraception during treatment with Letairis and for one month after stopping therapy? ❑Yes ❑No

d. Has Letairis been prescribed by or recommended by either a cardiologist or pulmonologist? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

a. Have the patient's symptoms improved or stabilized with therapy? ❑Yes ❑No

b. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes***** ***(*If YES, please answer questions 1 and 2 below)*** ❑No

1) Will pregnancy be excluded during treatment with Letairis? ❑Yes ❑No

2) Will the patient be advised to use an acceptable method of contraception during treatment with Letairis and for one month after stopping therapy? ❑Yes ❑No