BlueCross BlueShield Federal Employee Program

OPSYNVI
PRIOR APPROVAL REQUEST

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

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.

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					

Opsynvi

(macitentan and tadalafil)

****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

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)
❑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)***: _____

2. Does the prescriber agree to monitor for pulmonary edema and discontinue this medication if confirmed? ❑Yes ❑No
3. Does the prescriber agree to counsel and evaluate the patient for sudden loss of vision or hearing associated with this medication? ❑Yes ❑No
4. Does the patient have severe hepatic impairment (Child-Pugh Class C)? ❑Yes ❑No
5. Does the patient have severe renal impairment defined as creatinine clearance less than 30 mL/min? ❑Yes ❑No
6. Will this medication be used in combination with another *phosphodiesterase-5 (PDE5) inhibitor? ❑Yes* ❑No
   If YES, please specify the medication: _____
   PDE5 Inhibitors: Viagra/Revatio (sildenafil), Cialis/Adcirca (tadalafil), Levitra/Staxyn (vardenafil), Stendra (avanafil)
7. Will this medication be used in combination with *guanylate cyclase (GC) stimulators? ❑Yes* ❑No
   If YES, please specify the medication: _____
   GC Stimulators: Adempas (riociguat), Verquvo (vericiguat)
8. Will this medication be used in combination with *alpha blockers? ❑Yes* ❑No
   If YES, please specify the medication: _____
   Alpha Blockers: alfuzosin (Uroxatral), doxazosin (Cardura/XL), prazosin (Minipress), silodosin (Rapaflo), tamsulosin (Flomax, Jalyn etc.), terazosin (Hytrin)

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS

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

9. Will this medication be used in combination with ***nitrates in any form? ❑Yes*** ❑No

***If YES**, please specify the medication: _____

***Nitrates: isosorbide dinitrate (Isordil), isosorbide mononitrate (Imdur, Ismo), nitroglycerin tablets, capsules, or patches (Nitro-Dur), isosorbide dinitrate/hydralazine (BiDil)**

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

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

a. Which level of activity causes the patient to experience shortness of breath or fatigue? ***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. Is there an absence of clinically significant anemia? ❑Yes ❑No

c. Has this medication been prescribed or recommended by a cardiologist or pulmonologist? ❑Yes ❑No

d. **FEMALE Patient**: Please answer the following questions:

i. Are the patient and prescriber enrolled in the Macitentan-Containing Products REMS program? ❑Yes ❑No

ii. Is the patient of reproductive potential? ❑Yes*** (*If YES, please answer the following questions)*** ❑No

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

2) Will the patient be advised to use effective contraception during treatment with Opsynvi and for one month after the last dose? ❑Yes ❑No

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

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

b. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes* ❑No

***IF YES**, will the patient be advised to use effective contraception during treatment with Opsynvi and for one month after the last dose? ❑Yes ❑No