BlueCross BlueShield Federal Employee Program®

TRACLEER
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

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

Tracleer (bosentan)

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

Please select strength: ❑**32mg** ❑**62.5mg** ❑**125mg**

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

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

BRAND Tracleer 62.5mg or 125mg Request (Standard Option Patient): Would you like to switch the patient to the preferred product, generic Tracleer (bosentan)? ❑Yes, switch to generic Tracleer (bosentan) ❑No, do not switch*****

If NO, does the patient have an intolerance or contraindication or have they had an inadequate treatment response to generic Tracleer (bosentan)? ***Please select answer below:***

❑**Yes**, specify result: _____

❑**No**: Is there a clinical reason for not trying bosentan (**generic** Tracleer)? ❑Yes***** ❑No

If YES, please specify: _____

GENERIC Tracleer 62.5mg or 125mg Request (Standard Option Patient): Is generic Tracleer (bosentan) being requested as a change from **BRAND** Tracleer 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)
❑Other cause ***(please specify)***: _____

❑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 diagnosis ***(please specify)***: _____

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

If YES, will pregnancy be excluded before and during treatment with Tracleer? ❑Yes***** ❑No

If YES, will the patient be advised to use two reliable forms of contraception during treatment and for one month after stopping Tracleer? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R_____

3. Is the patient receiving therapy with cyclosporine A, glyburide (Diabeta, Micronase, Glynase), or Glucovance (glyburide / metformin)? ❑Yes ❑No

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

5. Has Tracleer been prescribed by or recommended by either a cardiologist or pulmonologist? ❑Yes ❑No

6. Are the patient and prescriber enrolled in and meet all the conditions of the bosentan REMS program? ❑Yes ❑No

7. 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. 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 activity (Class I)
- ❑ Mild symptoms and slight limitations 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)

❑ **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

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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.***

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Tracleer – FEP MD Fax Form Revised 5/13/2022