BlueCross BlueShield Federal Employee Program

UPTRAVI
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					

Uptravi (selexipag)

****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. Is this request for Uptravi tablets or IV infusion? ***Please select answer below:***
   - ❑**IV Infusion:** This request needs to be billed under the medical benefit
   - ❑**Tablets:** Please answer the questions below for tablets
2. Is this request for brand or generic? ❑Brand ❑Generic
3. How many tablets will the patient need for a 90 day supply after initiation/titration? _____ tablet(s) per 90 days
4. 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)***: _____
5. Does the patient have severe hepatic impairment (Child-Pugh Class C)? ❑Yes ❑No
6. Does the physician agree to monitor the patient for signs and symptoms of pulmonary edema and discontinue Uptravi if confirmed? ❑Yes ❑No
7. 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. What level of activity causes the patient to experience shortness of breath or fatigue? ***Please select level of activity below:***
      - ❑No symptoms and no limitations in ordinary activity (Class I)
      - ❑Mild symptoms and slight limitation during ordinary activity (Class II)
      - ❑Marked limitation in activity due to symptoms (Class III)
      - ❑Experiences shortness of breath and fatigue while at rest (Class IV)

   b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to endothelin receptor antagonists (ERA) or phosphodiesterase type 5 inhibitors (PDE-5)? ❑Yes ❑No

      Examples include Letairis (ambrisentan), Tracleer (bosentan), Opsumit (macitentan), Revatio (sildenafil), Adcirca (tadalafil)

   c. Has this medication 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 question:

   a. Has 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.***