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

All approved requests for BRAND LETAIRIS are subject to review by a clinical specialist for final validation and coverage determination once all required documentation has been received. Current utilization, including samples, does not guarantee approval of coverage. SUBMITTING THE PATIENT'S MEDICAL RECORDS IS REQUIRED.

Generic 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

1. Is this request for brand or generic? ***Please select answer below:***
   - ❑ **BRAND Letairis** – Please answer the questions on **PAGE 3**
   - ❑ **GENERIC Letairis (ambrisentan)** – Please answer the questions below:

2. Is generic Letairis (ambrisentan) being requested as a change from **BRAND** Letairis? ❑Yes ❑No

3. Will the patient need more than 90 tablets every 90 days? ❑Yes***** ❑No
   ****If YES***, please specify the requested quantity: _____ tablets every 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 prescriber agree to monitor the patient for pulmonary edema and to discontinue therapy if confirmed? ❑Yes ❑No

6. 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 _____

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. 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)

❑Experience 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

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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

All approved requests for BRAND LETAIRIS are subject to review by a clinical specialist for final validation and coverage determination once all required documentation has been received. Current utilization, including samples, does not guarantee approval of coverage. SUBMITTING THE PATIENT'S MEDICAL RECORDS IS REQUIRED.

Brand 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

DOCUMENTATION IS REQUIRED: Please ensure that all relevant medical records are submitted along with the correct page number(s).

1. Is this request for brand or generic? ***Please select answer below:***
   - ❑ **GENERIC Letairis (ambrisentan)** – Please answer the questions on **PAGE 1**
   - ❑ **BRAND Letairis** – Please answer the questions below:

2. **Standard/Basic Option Patient:** Has the patient tried and failed generic Letairis (ambrisentan)? ***Please select answer below:***
   - ❑ **YES –Please specify the medical record page number(s). PAGE(s)_____ of _____**
   - ❑ **NO – The patient has not tried and failed generic Letairis (ambrisentan).** ***Please answer the below questions:***
     a. Would you like to switch to the preferred medication? The preferred medication is generic Letairis (ambrisentan).
     - ❑ **YES –** Switch to generic Letairis (ambrisentan).
     - ❑ **NO –** Do not switch.
     - ❑ **NO –** Do not switch however the patient has a medical exception. **Please specify the medical record page number(s). PAGE(s)_____ of _____**
     - ❑ **NO –** Do not switch however I would like to speak with a medical director to discuss the case. **Please specify the preferred date and time to contact, including the time zone, and the phone number:_____**
       _____

3. **Blue Focus Patient -** ***Please answer the questions below:***
   a. This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed. ***Please answer below:***
   - ❑**Please specify the formulary alternative medication(s) and medical record page number(s):**
     PAGE(s)_____ of _____ Formulary alternative medication(s):_____
     _____
   - ❑ **The patient has not tried and failed any formulary alternatives.**

   b. Would you like to switch to the preferred medication? The preferred medication is generic Letairis (ambrisentan). ❑Yes ❑No

4. Will the patient need more than 90 tablets every 90 days? ❑Yes***** ❑No
   ****If YES***, please specify the requested quantity: _____ tablets every 90 days

PLEASE PROCEED TO PAGE 4 FOR ADDITIONAL QUESTIONS

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PAGE 2 - PHYSICIAN COMPLETES

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

5. What is the patient's diagnosis? **DOCUMENTATION IS REQUIRED: Please ensure that all relevant medical records are submitted along with the correct page number(s).**

❑ Pulmonary arterial hypertension (PAH) (WHO Group 1)**, please specify the medical record page number(s) below: PAGE(s)_____ of _____**

❑ Pulmonary hypertension**, please specify the medical record page number(s). PAGE(s)_____ of _____**

a. What is the cause of the pulmonary hypertension? **Please select answer below and specify the medical record page number(s). PAGE(s)_____ of _____**

❑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)
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❑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):*** _____

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

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

8. 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 and specify the medical record page number(s). PAGE(s)_____ of _____**

❑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)

b. Does the patient have clinically significant anemia? ❑Yes ❑No*
***If NO*, please specify the medical record page number(s). PAGE(s)_____ of _____**

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
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

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