**Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.**
**LETAIRIS (Ambrisentan), TRACLEER (Bosentan), OPSUMIT (Macitentan)**
**Prior Authorization (PA)**
**Pharmacy Benefits Prior Authorization Help Desk**
**Length of Authorizations: Initial- 12 months; Continuation- 12 months**

**Instructions:**

This form is used by Kaiser Permanente and/or participating providers for coverage **LETAIRIS (Ambrisentan), TRACLEER (Bosentan), OPSUMIT (Macitentan).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete. KP-MAS Formulary can be found at: http://www.providers.kaiserpermanente.org/mas/formulary.html**

**1 – Patient Information**

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

**2 – Prescriber Information**

Is the prescriber a Pulmonologist or Cardiologist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

**3 – Pharmacy Information**

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

**4 – Drug Therapy Requested**

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

**5– Diagnosis/Clinical Criteria**

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, State date: _____
2. Indicate the Member's diagnosis for the requested medication: _____
3. Does the member have a diagnosis of pulmonary arterial hypertension World Health Organization [WHO] Group I? **OR**
   □ No □ Yes
4. Does the member have a diagnosed with WHO/New York Heart Association Functional Class II, III or IV symptoms? **AND**
   □ No □ Yes
5. Is the member pregnant? **AND**
   □ No □ Yes
6. Is there documentation of treatment failure, intolerance or contraindication to bosentan (generic Tracleer), ambrisentan (generic Letairis)?
   □ No □ Yes

For Letairis (ambrisentan) only:

1. Does member have a diagnosed with idiopathic pulmonary fibrosis?
   □ No □ Yes

For Opsumit (macitentan) only:

1. Is there documentation treatment failure, intolerance or contraindication to bosentan (generic Tracleer), ambrisentan (generic Letairis)?
   □ No □ Yes

**For Continuation of Therapy, Please Respond to Additional Questions Below:**

1. Is there documentation the member is experiencing clinical benefit from therapy as evidenced by disease stability or disease improvement? **AND**
   □ No □ Yes
2. Does member continue to meet initial review criteria?
   □ No □ Yes

**6 – Prescriber Sign-Off**

**Additional Information – Please submit chart notes/medical records for the patient that are applicable to this request. Provide any additional supporting information that should be taken into consideration:**

_____

**I certify that the information provided is accurate. Supporting documentation is available for State audits.**

| **Prescriber Signature:** | **Date:** |
|---|---|
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