Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
ADEMPAS (Riociguat) 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 **ADEMPAS (Riociguat).** 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 member diagnosed with WHO/New York Heart Association Functional Class II, III or IV symptoms? **AND**
   □ No □ Yes
4. Is member pregnant? **AND**
   □ No □ Yes
5. Does member have pulmonary hypertension associated with idiopathic interstitial pneumonias (PH-IIP)? **AND**
   □ No □ Yes
6. Is there documentation treatment failure, intolerance, or contraindication to sildenafil or tadalafil (phosphodiesterase-5 inhibitors)? **AND**
   □ No □ Yes
7. Is there documentation treatment failure, intolerance, or contraindication to ambrisentan (generic Letairis®) or bosentan (generic Tracleer) or macitentan (Opsumit®)? **AND**
   □ No □ Yes
8. Is member currently receiving intravenous prostanoid analogues (e.g. treprostinil (Remodulin®) or epoprostenol (Flolan®)) orphosphodiesterase type (PDE-5) inhibitor (e.g. sildenafil (Revatio®), tadalafil (Adcirca®))?

<u>Chronic Thromboembolic Pulmonary Hypertension (CTEPH)</u>

9. Does the member have a diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH)?
   □ No □ Yes
10. Is the member pregnant? **AND**
    □ No □ Yes
11. Is the member a candidate for pulmonary endarterectomy? **OR**
    □ No □ Yes
12. Is there a persistent recurrent CTEPH after pulmonary endarterectomy based on pulmonology/cardiology recommendations?
    □ 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 the 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:**