Letairis (ambrisentan)

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What drug is being prescribed? ❑ Letairis ❑ ambrisentan
2. What is the diagnosis?
   ❑ Pulmonary arterial hypertension (PAH)
   ❑ Other _____
3. What is the ICD-10 code? _____

Complete the following questions if Letairis is being prescribed. If ambrisentan is being prescribed, skip to #9.

4. Is the product being requested for the treatment of pulmonary arterial hypertension (PAH) WHO Group 1?
   ❑ Yes ❑ No *If No, skip to #9*
5. The preferred products for your patient's health plan are ambrisentan, bosentan, and Opsumit. Can the patient's treatment be switched to a preferred product? ***If Yes, fax a new prescription to the pharmacy.***
   ❑ Yes - bosentan ❑ Yes - Opsumit
   ❑ Yes - ambrisentan, *skip to #9* ❑ No - Continue request for Letairis
6. Does the patient have a documented inadequate response or intolerable adverse event to treatment with both of the preferred products, bosentan and Opsumit? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).***
   ❑ Yes ❑ No *If No, complete this form in its entirety and State Step Therapy section.*
7. Does the patient have a documented intolerable adverse event to the preferred product ambrisentan?
   ACTION REQUIRED: If Yes, attach supporting chart note(s). ❑ Yes ❑ No *If No, complete this form in its entirety and State Step Therapy section.*
8. Was the documented intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information? ***ACTION REQUIRED: If No, attach supporting chart note(s).***
   If Yes, complete this form in its entirety and State Step Therapy section. ❑ Yes ❑ No
9. Is the request for continuation of therapy with the requested medication? ❑ Yes ❑ No *If No, skip to #12*
10. Is the patient currently receiving the requested medication through a paid pharmacy or medical benefit?
    ❑ Yes ❑ No ❑ Unknown *If No or Unknown, skip to #12*

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

 Letairis [ambrisentan] State Step, ACSF SGM - 12/2020.

11. Is the patient experiencing a benefit from therapy with the requested medication as evidenced by disease stability or disease improvement? ❑ Yes ❑ No *No further questions*

12. What is the World Health Organization (WHO) classification of pulmonary hypertension?
    ❑ **WHO Group 1** (Pulmonary arterial hypertension)
    ❑ **WHO Group 2** (Pulmonary hypertension owing to left heart disease)
    ❑ **WHO Group 3** (Pulmonary hypertension owing to lung disease and/or hypoxia)
    ❑ **WHO Group 4** (Chronic thromboembolic pulmonary hypertension)
    ❑ **WHO Group 5** (Pulmonary hypertension with unclear multifactorial mechanisms)

13. Has PAH been confirmed by right heart catheterization? ❑ Yes ❑ No *If No, skip to #17*

14. What is the pretreatment mean pulmonary arterial pressure at rest? _____ mmHg

15. What is the pretreatment pulmonary capillary wedge pressure? _____ mmHg

16. What is the pretreatment pulmonary vascular resistance? _____ Wood units *No further questions*

17. Is the patient an infant less than one year of age? ❑ Yes ❑ No

18. Has Doppler echocardiogram been performed to diagnose PAH? ❑ Yes ❑ No

State Step Therapy

1. Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? ❑ Yes ❑ No

2. Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? ❑ Yes ❑ No

3. Does the patient reside in Maryland? ❑ Yes ❑ No *If No, skip to #7*

4. Is the alternate drug (ambrisentan, bosentan, Opsumit) FDA-approved for the medical condition being treated? ❑ Yes ❑ No *If No, please specify:* _____

5. Has the prescriber provided proof, documented in the patient's chart notes, indicating that the requested drug was ordered for the patient in the past 180 days? ❑ Yes ❑ No *If No, skip to #7*

6. Has the prescriber provided proof, documented in the patient chart notes, that in their opinion the requested drug is effective for the patient's condition? ❑ Yes ❑ No *No further questions*

7. Are any of the following conditions met for the alternate drug (ambrisentan, bosentan, Opsumit)?
    ❑ The alternate drug is contraindicated
    ❑ The alternate drug is likely to cause an adverse reaction, physical or mental harm
    ❑ The alternate drug is expected to be ineffective
    ❑ The alternate drug was previously tried or a drug in the same class or with the same action was previously tried and was stopped due to ineffectiveness or an adverse event
    ❑ The alternate drug is not in the patient's best interest
    ❑ The alternate drug was tried while covered by the current or the previous health benefit plan
    ❑ None of the above
    If Yes, please specify: _____

8. Is the patient stable or currently receiving a positive therapeutic outcome with the requested drug and a change in the prescription drug is expected to be ineffective or cause harm to the patient? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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