

# Pharmacy

## PRIOR AUTHORIZATION FORM

For Prior Authorization, please fax to: (877) 974-4411 toll free, or (616) 942-8206

This form applies to:  Commercial Plan  Medicaid Plan  Medicare Plan

### LETAIRIS<sup>®</sup> (ambrisentan)

**URGENT** (life threatening)

**Non-Urgent** (standard review)

A claim involving "urgent care" applies when the standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

#### Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

#### Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

#### PRODUCT INFORMATION

- LETAIRIS<sup>®</sup> 5 mg  
 LETAIRIS<sup>®</sup> 10 mg

**Start Date:** \_\_\_\_\_ **Dosing frequency:** \_\_\_\_\_

#### PRIORITY HEALTH PRECERTIFICATION REQUIREMENTS

Authorization for LETAIRIS<sup>®</sup> (ambrisentan) requires the following information to certify:

To certify this request, all of the following criteria must be met:

1. The medication is being used only for pulmonary arterial hypertension (PAH) for improvement of exercise capacity and to delay clinical worsening.
2. The patient's PAH classification meets World Health Organization Group 1 criteria.

**Note:** When approved, coverage for LETAIRIS<sup>®</sup> is limited to 10 mg daily.

---

**PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION IS REQUIRED FOR REIMBURSEMENT**

Authorization for LETAIRIS<sup>®</sup> (ambrisentan) requires the following information to certify:

---

**1. What is the patient's diagnosis?**a.  Pulmonary arterial hypertensionb.  Other: \_\_\_\_\_*Rationale for use:* \_\_\_\_\_

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

**2. What is the patient's WHO classification of PAH?**a.  Group 11.1  Idiopathic PAH1.2  Heritable1.2.1  BMPR21.2.2  ALK1, endoglin1.2.3  Unknown1.3  Drug- and toxin-induced1.4  Associated with1.4.1  connective tissue disorder1.4.2  HIV infection1.4.3  Portal hypertension1.4.4  Congenital heart disease1.4.5  Schistosomiasis1.4.6  Chronic hemolytic anemia1.5  Persistent pulmonary hypertension of the newbornb.  Group 2 (LETAIRIS<sup>®</sup> is not covered)c.  Group 3 (LETAIRIS<sup>®</sup> is not covered)d.  Group 4 (LETAIRIS<sup>®</sup> is not covered)e.  Group 5 (LETAIRIS<sup>®</sup> is not covered)

\*\*\* All fields must be complete and legible for Prior Authorization Review\*\*\*

**Please fax this request to: (877)974-4411 toll free or (616)942-8206**

**YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**