



Send completed form to:
 Peach State Health Plan Pharmacy Department
 Fax: 1-866-374-1579

Letairis

Prior Authorization Request

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 toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copay or medication delivery; please contact Peach State Health Plan at 1-800-514-0083 option # 2.

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

1. Which drug is being prescribed?
 Letairis, Dose: _____ Frequency: _____ Other _____
2. What is the diagnosis?
 Pulmonary arterial hypertension (PAH) WHO Group 1
 Other _____
3. How old is the patient? _____ years
4. Has PAH been confirmed by right heart catheterization (defined as mean pulmonary pressure greater than 25 mmHg at rest or greater than 30 mmHg with exercise)? Yes No **(Fax Results)**
5. If the patient is female, is the patient pregnant? Yes No Patient is Male
6. Is the patient currently receiving Letairis for PAH? **If Yes, no further questions* Yes No
7. Has the patient previously received any prostanoid (e.g. Flolan, Veletri, Remodulin, Tyvaso, Ventavis), phosphodiesterase inhibitor (e.g. Adcirca, Revatio), or endothelin antagonist (e.g. Tracleer) for PAH?
Indicate all of the below therapies the patient has previously received, if none, mark "None of the above"
 Adcirca Remodulin Tracleer Veletri None of the above
 Flolan Revatio Tyvaso Ventavis
8. Has the patient had an inadequate response to vasoreactivity testing?
**If Yes, skip to #11* Yes No
9. Has the patient had a prior trial and failure of calcium channel blocker (CCB)?
**If Yes, skip to #11* Yes No
10. Does the patient have a contraindication to calcium channel blocker (CCB) (e.g. right sided heart failure, left ventricular dysfunction)? Yes No
11. Has the patient **tried and failed** a trial of Adcirca? Yes No

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Patient Name: _____ Patients Date of Birth: _____
Patients ID : _____

12. If No, is the patient contraindicated to Adcirca therapy? Yes No
13. Does the patient experience NYHA Class II or III symptoms? Yes (*indicate below*) No
- NYHA Class II symptoms
 - NYHA Class III symptoms

****NOTE: We can NOT make a decision without a copy of lab results - Thank You****

Information given on this form is accurate as of this date:

X _____
Prescriber or Authorized Signature Date (mm/dd/yy)

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