



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

Tracleer

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 copy 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. What drug is being prescribed? Tracleer Other _____
2. Indicate Prescribed Dose: Dose: _____ Frequency: _____
3. What is the diagnosis?
 Pulmonary arterial hypertension (PAH) WHO Group 1 Other _____
4. **What is the ICD-9?** _____
5. How old is the patient? _____ years
6. 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)**
7. If the patient is female, is the patient pregnant? Yes No Patient is Male
8. Does the patient have liver impairment (liver function tests [LFTs] greater than 3 times the upper limit of normal [ULN] and/or bilirubin greater than or equal to 2 times [ULN])? Yes No
(Fax LFT results)
9. Document: BASELINE LFTs: _____ OR CURRENT LFTs: _____
10. Is the patient currently taking glyburide or cyclosporine? Yes No
11. Is the patient currently receiving Tracleer for PAH? **If Yes, no further questions.* Yes No
12. 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. Letairis) for PAH?
 Yes No **Indicate all of the below therapies the patient has previously received**
 Adcirca Letairis Revatio Veletri None of the above
 Flolan Remodulin Tyvaso Ventavis
13. Has the patient had an inadequate response to vasoreactivity testing?
**If Yes, Skip to #16* Yes No

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

14. Has the patient had a prior trial and failure of calcium channel blocker (CCB)?
*If Yes, Skip to # 16 Yes No
15. Does the patient have a contraindication to calcium channel blocker (CCB) (e.g. right sided heart failure, left ventricular dysfunction)? Yes No
16. Has the patient **tried and failed** a trial of Adcirca? Yes No
17. If No, is the patient contraindicated to Adcirca therapy? Yes No
18. Does the patient experience NYHA Class II, III, or IV symptoms? Yes (*indicate below*) No
 NYHA **Class II** symptoms
 NYHA **Class III** symptoms
 NYHA **Class IV** symptoms

****NOTE: We can NOT make a decision without documentation - 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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