Prior Authorization Request Form for
riociguat **(Adempas)**

JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: ____________________ Physician Name: ____________________
Address: ____________________ Address: ____________________
____________________ ____________________
Sponsor ID # ____________________ Phone #: ____________________
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

Question	Yes	No
1. Is the requested medication being prescribed by or in consultation with a cardiologist or a pulmonologist?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Is the patient taking PDE-5 inhibitors or nitrate drugs at the same time? *(for example, amyl nitrite, BiDil, Dilatrate-SR, IsoDitrate ER, Isordil, isosorbide dinitrate, isosorbide mononitrate, Nitro-Bid, Nitro-Dur, nitroglycerin, Nitrolingual, NitroMist, Nitrostat, Nitro-Time, Rectiv)*	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **3**
3. Does the patient have a documented diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH) WHO Group 4 PAH?	☐ Yes **Sign and date below**	☐ No Proceed to question **4**
4. Does the patient have a documented diagnosis of WHO group 1 PAH?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. Has the patient had a right heart catheterization?	☐ Yes Proceed to question **6**	☐ No **STOP** Coverage not approved
6. Is documentation being provided to confirm that the patient has had a right heart catheterization? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Documentation may include, but is not limited to, chart notes and catheterization laboratory reports.	☐ Yes Proceed to question **7**	☐ No **STOP** Coverage not approved

7. Did the results of the right heart catheterization confirm the diagnosis of WHO Group 1 PAH?	☐ Yes Proceed to question **8**	☐ No **STOP** Coverage not approved
8. Has the patient had an adequate trial of sildenafil 20 mg (brand Revatio, generics) and failed or did not respond to therapy?	☐ Yes Proceed to question **9**	☐ No **STOP** Coverage not approved
9. Has the patient had an adequate trial of tadalafil 40 mg (Adcirca, generics) and failed or did not respond to therapy?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature ______________________ Date __________

[23 October 2019]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: