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

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

USFHP Pharmacy Prior Authorization Form

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:**

1. Does the patient have a documented diagnosis of WHO group 1 PAH?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication being prescribed by or in consultation with a cardiologist or a pulmonologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Has the patient had a right heart catheterization?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. 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 **5**	☐ No **STOP** **Coverage not approved**
5. Did the results of the right heart catheterization confirm the diagnosis of WHO Group 1 PAH?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Is the patient and provider enrolled in the Letairis or Opsumit REMS program?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

Continue on next page

Prior Authorization Request Form for ambrisentan (Letairis), macitentan (Opsumit)

7. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **8**
8. Is the patient a women of childbearing potential?	☐ Yes Proceed to question **9**	☐ No Proceed to question **10**
9. Is adequate contraception being used?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Does the patient have history of liver function test (LFT) elevations on previous endothelin receptor antagonist (ERA) therapy, accompanied by signs or symptoms of liver toxicity or increases in bilirubin greater than two times the upper limit of normal?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **11**
11. Does the patient have moderate or severe liver impairment (for example, Child-Pugh Class B or C)?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

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: