Prior Authorization Request Form for
bosentan (**Tracleer**)

JOHNS HOPKINS MEDICINE
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:**

1. Is the requested medication being prescribed by or in consultation with a cardiologist or pulmonologist?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. What is the indication or diagnosis?	☐ WHO group 1 - Proceed to question **3** ☐ WHO group 4 - Proceed to question **6** ☐ Other indication or diagnosis – **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?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
6. Has the patient tried Adempas or have a contraindication to Adempas?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

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7. Is the patient and provider enrolled in the Tracleer REMS program?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **9**
9. Is the patient a women of childbearing potential?	☐ Yes Proceed to question **10**	☐ No Proceed to question **11**
10. Is adequate contraception being used?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Does the patient have baseline elevated aminotransferases greater than three times the upper limit of normal due to difficulty in monitoring for hepatotoxicity?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **12**
12. 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: