

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross[®] BlueShield[®] of South Carolina

Patient Information	
Name:	Insurance ID #:
Address:	Birthdate:

Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

When this form is complete, please fax to Caremark at 888-836-0730.

This fax machine is in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 800-294-5979 with any questions concerning prior authorization procedures.

- Does the patient have a diagnosis of pulmonary arterial hypertension (PAH) (WHO Group 1)?
[If the answer to this question is no, no further questions are required.] Y N
- Has PAH been confirmed by right heart catheterization?
[If the answer to this question is yes, skip to question 5.] Y N
- Is the patient an infant with any of the following conditions?
 - Post cardiac surgery
 - Chronic lung disease associated with prematurity
 - Chronic heart disease
 - Congenital diaphragmatic hernias
 [If the answer to this question is no, no further questions are required.] Y N
- Has Doppler echocardiogram been performed to diagnose PAH?
[If the answer to this question is no, no further questions are required.] Y N
- Does the patient experience New York Heart Association (NYHA) Class II or III symptoms?
[If the answer to this question is no, no further questions are required.] Y N
- Does the patient have a serum aminotransferase (AST, ALT) level >3 times the upper limit of normal (ULN)?
[If the answer to this question is yes, no further questions are required.] Y N
- Is the patient a female of childbearing potential?
[If the answer to this question is no, no further questions are required.] Y N

LETAIRIS

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8. Has pregnancy been excluded as confirmed by a negative urine or serum pregnancy test prior to initiation of Letairis therapy and will be excluded monthly during the therapy?
[If the answer to this question is no, no further questions are required.] Y N
9. Will the patient consistently use either an intrauterine device (IUD) or two appropriate contraceptive methods for the duration of Letairis therapy? Y N

Comments: _____

Information on this form is accurate as of the date below.

Prescriber's Signature:	Date:
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