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| **PHARMACY COVERAGE GUIDELINES** | **ORIGINAL EFFECTIVE DATE: 6/19/14** |
| **SECTION: DRUGS** | **LAST REVIEW DATE: 3/15/18** |
| | **LAST CRITERIA REVISION DATE: 3/15/18** |
| | **ARCHIVE DATE:** |

# ADEMPAS® (riociguat) oral tablet
# ORENITRAM™ (treprostinil ER) oral tablet

**Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pharmacy Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.**

**This Pharmacy Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.**

**The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.**

**The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.**

**State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.**

**Pharmacy Coverage Guidelines are subject to change as new information becomes available.**

**For purposes of this Pharmacy Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.**



This Pharmacy Coverage Guideline does not apply to FEP or other states' Blues Plans.

Information about medications that require precertification is available at www.azblue.com/pharmacy.

Some large (100+) benefit plan groups may customize certain benefits, including adding or deleting precertification requirements.

All applicable benefit plan provisions apply, e.g., waiting periods, limitations, exclusions, waivers and benefit maximums.

Precertification for medication(s) or product(s) indicated in this guideline requires completion of the request form in its entirety with the chart notes as documentation. All requested data must be provided. Once completed the form must be signed by the prescribing provider and faxed back to BCBSAZ Pharmacy Management at (602) 864-3126 or emailed to Pharmacyprecert@azblue.com. **Incomplete forms or forms without the chart notes will be returned.**

## ADEMPAS® (riociguat) oral tablet
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**Description:**

Pulmonary hypertension (PH) may be characterized by restricted or reduced blood flow through the pulmonary artery, pulmonary vein, or pulmonary capillaries, leading to complaints of shortness of breath, dizziness, fainting, fatigue, chest pain, palpitations, leg swelling and other symptoms. PH is a severe progressive disease with markedly decreased exercise tolerance, heart failure and ultimately death. The rate of progression is highly variable.

PH may be categorized, using the World Health Organization (WHO) scheme, into five classes or groups based on etiology and may be further characterized using the New York Heart Association (NYHA) Functional Class system modified for PH that is based on activity level and symptoms in an attempt to categorize severity of disease clinically. It should be noted that while together all groups are called pulmonary hypertension, WHO Group 1 is called PAH and WHO Groups 2 through 5 are called PH. Other factors are also used to determine an individual's risk category and assessment of prognosis. WHO Functional Class I are those individuals least affected by their disease while those in WHO NYHA Functional Class IV are most affected.

Pulmonary arterial hypertension (PAH) is placed in WHO Group I and includes a large number of disorders. It is important to distinguish PAH from other types of PH as PH from other causes is thought to differ pathophysiologically from PAH and may be managed differently.

The pathogenesis of PAH (WHO Group 1) is complex and incompletely understood; it is thought to involve an imbalance between vasoconstriction, vasodilation, and abnormal cellular proliferation. It includes genetic, inflammatory, and environmental factors that alter vascular structure and function in smooth muscle, endothelial cells, and adventitia. Included in this complexity are endothelial dysfunction (favoring vasoconstriction, thrombosis, and mitogenesis); increased levels of thromboxane A2, endothelin-1 (ET-1), and serotonin (5HT) which stimulate vasoconstriction, cell proliferation, and thrombosis; decreased levels of prostacyclin, nitric oxide, and vasoactive intestinal peptide (VIP) which favor vasoconstriction, cell proliferation, and thrombosis; and low levels of other mediators such as vascular endothelial growth factor (VGEF). VEGF is a signal protein that stimulates creation of new blood vessels which restore oxygen supply to tissues when blood flow is inadequate.

The pathogenesis of pulmonary hypertension from left heart disease (WHO Group II) is completely different. There is no obstruction to blood flow in the lungs. Instead, the left heart fails to pump blood efficiently, leading to pooling of blood, causing pulmonary edema and pleural effusions. In hypoxic pulmonary hypertension (WHO Group 3), low levels of oxygen are thought to cause vasoconstriction of pulmonary arteries. In chronic thromboembolic pulmonary hypertension (CTEPH or WHO Group 4), the blood vessels are blocked or narrowed with blood clots. These last two groups share some similar pathophysiology as PAH (WHO Group 1).

For individuals with CTEPH, thromboendarterectomy is considered the treatment of choice in those who have surgically accessible disease and an acceptable surgical risk. The goal of surgery is to remove enough embolic material from the pulmonary arteries to lower pulmonary vascular pressure and improve cardiac output. Individuals who are inoperable are managed with medications.

A baseline assessment to determine PAH severity is performed before initiating therapy. Therapy should not be administered unless a diagnostic right heart catheterization (RHC) and extensive investigations for the etiology of PH have been performed. This assessment includes the following three key measures:

## ADEMPAS® (riociguat) oral tablet
## ORENITRAM™ (treprostinil ER) oral tablet (cont.)

1. Functional impairment: This is determined by measuring exercising capacity and determining WHO or NYHA Functional Class.

2. Hemodynamic derangement: The diagnosis of PH can be suspected based on echocardiography. However, a RHC is performed to accurately measure hemodynamic parameters and confirm PAH. Individuals with PAH typically undergo an invasive hemodynamic assessment and an acute vasoreactivity test before the initiation of advanced therapy. The hemodynamic definition of PAH is a mean pulmonary artery pressure greater than 25 mm Hg at rest. A pulmonary arterial wedge pressure or left ventricular end-diastolic pressure of less than 15 mm Hg is needed to exclude WHO Group II PH (due to left heart disease). PAH is also supported by increased pulmonary vascular resistance and transpulmonary gradient.

3. Acute vasoreactivity test: The test involves administration of a short-acting vasodilator, then measuring hemodynamic response with a right heart catheter. An acute vasoreactivity test is considered positive if mean pulmonary artery pressure decreases by at least 10 mm Hg and to a value less than 40 mm Hg, with an increased or no change in cardiac output and a minimally reduced or no change in systemic blood pressure.

Since endothelial dysfunction, impaired synthesis of nitric oxide (NO) and insufficient stimulation of the NO and cyclic guanosine monophosphate (cGMP) pathway are thought to play a role in the pathology of PH, pharmacologic therapy aimed at modifying these abnormalities has been developed. Riociguat sensitizes soluble guanylate cyclase (sGC) to endogenous NO by stabilizing binding of NO to sGC. It also directly stimulates sGC independent of NO and it promotes the NO-sGC–cGMP pathway by stimulating the synthesis of cGMP, leading to increased generation of cGMP with subsequent vasodilation. cGMP plays an important role in regulating vascular tone, proliferation, fibrosis and inflammation. Riociguat is FDA approved for WHO group 4 who are inoperable CTEPH or for those who have persistent or recurrent CTEPH after surgical treatment. It is also FDA approved for PAH (WHO group 1) with functional class II or III symptoms.

Agents that are prostanoids are believed to cause vasodilation by mimicking the action of prostacyclin. They cause direct vasodilation of pulmonary and systemic arterial vascular beds, inhibit platelet aggregation, and inhibit smooth muscle proliferation. Prostanoids include Epoprostenol, Iloprost, and Treprostinil. Previously these agents were given by injection or inhalational delivery. A recently marketed oral prostanoid agent is now available.

A comprehensive guideline for treatment of pulmonary hypertension that incorporates all agents (old and new) into a treatment algorithm is not available. Previous guidelines typically have recommended treatment based on symptoms. In early and generally mildly symptomatic disease, oral therapy using a phosphodiesterase type-5 inhibitor or an endothelin receptor antagonist is usually recommended, although the injectable or inhalational agents could also be used. As symptoms progress, inhaled or injectable therapies are recommended initially. Combination therapy could be considered for individuals who do not improve with monotherapy.

Use of Adempas is subject to a Risk Evaluation and Mitigation Strategies (REMS) program that requires provider, patient, and dispensing pharmacy be enrolled into the program. Only providers and Pharmacies enrolled into the REMS may prescribe and dispense the drug, respectively, to individuals who are also in the program. A REMS program attempts to manage known or potentially serious risks associated with a drug product and is required by the Food and Drug Administration (FDA) for some drugs to ensure that the benefits of a drug outweigh its risks.

## ADEMPAS® (riociguat) oral tablet
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**Definitions:**

**Pulmonary Hypertension Association (PHA)**
The largest and oldest pulmonary hypertension (PH) association in the world. PHA is a community-based nonprofit support, education, advocacy and awareness association for PH.

**Pulmonary Hypertension Care Centers (PHCC)**
***Center of Comprehensive Care (CCC):***
A PHA accredited highly organized, full-time PH center that proficiently evaluates individuals with PH based on published evidence-based guidelines and provides expert treatment of individuals with PAH with all of the FDA-approved therapies. CCC also make important contributions to PH research and education.

***Regional Clinical Program (RCP):***
A PHA accredited center that proficiently evaluates individuals with PH based on published evidence-based guidelines and provides expert treatment of individuals with PAH with all non-parenteral therapies. A RCP must collaborate with its regional CCC by referring individuals that may benefit from opportunities unavailable at the RCP, including the initiation of advanced parenteral therapies and participation in clinical research protocols.

**WHO Group, classification of Pulmonary Hypertension (PH)**
- WHO Group 1 - Pulmonary arterial hypertension (PAH)
  - Idiopathic (IPAH)
  - Heritable / Familial
    - Activin receptor-like kinase (ALK1), endoglin (with or without hereditary hemorrhagic telangiectasia)
    - Bone Morphogenic Protein Receptor type II (BMPR)
    - Unknown
  - Drug- and toxin-induced
  - Associated with (APAH):
    - Congenital heart diseases – systemic to pulmonary shunts
    - Connective tissue disease
    - HIV infection
    - Portal hypertension
    - Schistosomiasis
  - Persistent pulmonary hypertension of the newborn
  - Associated with significant venous or capillary involvement
    - Pulmonary capillary hemangiomatosis (PCH)
    - Pulmonary veno-occlusive disease (PVOD)

- WHO Group 2 - Pulmonary hypertension owing to left heart disease
  - Left-sided arterial or ventricular heart disease
  - Left-sided valvular heart disease
  - Diastolic dysfunction
  - Systolic dysfunction

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- WHO Group 3 - Pulmonary hypertension owing to lung disease and/or hypoxia
  - Alveolar hypoventilation disorders
  - Chronic exposure to high altitude
  - Chronic obstructive pulmonary disease
  - Developmental abnormalities
  - Interstitial lung disease
  - Other pulmonary diseases with mixed restrictive and obstructive pattern
  - Sleep-disordered breathing

- WHO Group 4 - Pulmonary hypertension due to Chronic thromboembolic pulmonary hypertension (CTEPH)
  - Non-thrombotic pulmonary embolism (tumor, parasites, foreign material)
  - Thromboembolic obstruction of distal pulmonary arteries
  - Thromboembolic obstruction of proximal pulmonary arteries

- WHO Group 5 - Pulmonary hypertension with unclear multifactorial mechanisms
  - Hematologic diseases: chronic hemolytic anemia (including sickle cell disease), myeloproliferative disease, splenectomy
  - Metabolic disorders: glycogen storage disease, Gaucher disease, thyroid diseases
  - Systemic diseases: sarcoidosis, pulmonary Langerhans cell histiocytosis: lymphangioleiomyomatosis, neurofibromatosis, vasculitis
  - Others: tumor obstruction, fibrosing mediastinitis, chronic renal failure on dialysis, compression of pulmonary vessels, Hemoglobinopathies, Hereditary hemorrhagic telangiectasia

**WHO Functional Class (modified New York Heart Association (NYHA) for PH)**

Functional Class I

No limitation in physical activity; ordinary physical activity does not cause dyspnea, fatigue, chest pain, or near syncope

Functional Class II

Slight limitations in physical activity; ordinary physical activity produces dyspnea, fatigue, chest pain, or near-syncope; comfortable with no symptoms at rest

Functional Class III

Marked limitation of physical activity; less than ordinary physical activity produces dyspnea, fatigue, chest pain, or near-syncope; comfortable with no symptoms at rest

Functional Class IV

Unable to perform any physical activity without symptoms; dyspnea and/or fatigue present at rest, there are signs of right heart failure; discomfort increased by any physical activity

**Therapeutic classes of drugs used to treat pulmonary hypertension:**

Calcium Channel Blockers – used in a very select group of individuals
Dihydropyridine class preferred

Endothelin receptor antagonists – bind to receptors in endothelium and vascular smooth muscle
Ambrisentan (Letairis) – oral, relatively selective receptor antagonist

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Bosentan (Tracleer) – oral, non-selective receptor antagonist
Macitentan (Opsumit) – oral, non-selective receptor antagonist

Phosphodiesterase type 5 inhibitors – inhibits PDE-5, increased cAMP
Sildenafil (Revatio, and generics) – oral and IV
Tadalafil (Adcirca) – oral

Prostanoids – direct vasodilation of pulmonary & systemic arterial vascular beds, inhibits platelet aggregation
Epoprostenol (Flolan, Veletri, and generics) – continuous IV
Iloprost (Ventavis) – inhaled delivery system
Treprostinil:
Orenitram ER – oral
Remodulin – can be SQ or IV
Tyvaso – inhaled delivery system

Soluble Guanylate Cyclase Stimulators – stimulates NO cGMP pathway, increases cGMP
Riociguat (Adempas) – oral

Selective prostacyclin receptor (IP receptor) agonist
Selexipag (Uptravi) – oral

**The Child-Pugh classification system:**

The Child-Pugh classification is a scoring system used to determine the prognosis with cirrhosis. Scoring is based upon several factors: albumin, ascites, total bilirubin, prothrombin time, and encephalopathy, as follows:

| | Score: 1 point | Score: 2 points | Score: 3 points |
|---|---|---|---|
| Serum Albumin (g/dL) | >3.5 | 3.0 - 3.5 | <3.0 |
| Serum Bilirubin (mg/dL) | <2.0 | 2.0 - 3.0 | >3.0 |
| Prothrombin time (seconds) | 1 - 4 | 4 - 6 | >6 |
| Ascites | none | moderate | severe |
| Encephalopathy | none | mild | severe |

The three classes and their scores are:

- **Class A** is score 5 – 6: Well compensated
- **Class B** is score 7 – 9: Significant functional compromise
- **Class C** is score > 9: Decompensated disease

# Adempas (riociguat)
# Orenitram (treprostinil)

**Medication class:**
Soluble Guanylate Cyclase (sGC) Stimulator – Adempas
Prostacyclin; Prostaglandin; Vasodilator – Orenitram

**FDA-approved indication(s):**
- Adempas (riociguat)
  - Treatment of adults with persistent/recurrent chronic thromboembolic pulmonary hypertension (CTEPH), (WHO Group 4) after surgical treatment, or inoperable CTEPH, to improve exercise capacity and WHO functional class
  - Treatment of adults with pulmonary arterial hypertension (PAH), (WHO Group 1), to improve exercise capacity, WHO functional class and to delay clinical worsening
    - Efficacy was shown in patients on Adempas monotherapy or in combination with endothelin receptor antagonists or prostanoids. Studies establishing effectiveness included predominately patients with WHO functional class II–III
- Orenitram (treprostinil)
  - Treatment of pulmonary arterial hypertension (PAH) (WHO group 1) in patients with WHO functional class II-III symptoms to improve exercise capacity
    - When used as the sole vasodilator, the effect of Orenitram on exercise is about 10% of the deficit, and the effect, if any, on a background of another vasodilator is probably less than this

**Recommended Dose:**
- Adempas (riociguat)
  - 0.5-1 mg three times daily, increase by 0.5 mg three times daily no sooner than 2-weeks as tolerated
- Orenitram (treprostinil)
  - 0.25 mg twice daily or 0.125 mg three times daily, increase by 0.25 or 0.5 twice daily or 0.125 mg three times daily every 3-4 days

***Maximum dosage***
- Adempas (riociguat):
  - 2.5 mg three times daily, safety & effectiveness of higher doses have not been established
- Orenitram
  - Not stated

**Available Dosage Forms:**
- Adempas (riociguat):
  - 0.5 mg, 1 mg, 1.5 mg, 2 mg, and 2.5 mg tabs
  - Each strength is packaged as a bottle of 9, bottle of 90, or blister of 42
- Orenitram (treprostinil)
  - 0.125 mg, 0.25 mg, 1 mg, 2.5 mg and 5 mg extended release osmotic tabs

## ADEMPAS® (riociguat) oral tablet
## ORENITRAM™ (treprostinil ER) oral tablet (cont.)

- Each strength is packaged as a bottle of 10 or a bottle of 100

**Warnings, Precautions, and other Clinical Information:**

- Adempas (riociguat)
  - Females can only obtain Adempas through a REMS program, do not administer to a pregnant female, females of reproductive potential must have a negative pregnancy test before, during, and after stopping Adempas, prevent pregnancy by using effective contraception
  - Use in individual with pulmonary veno-occlusive disease (PVOD) is not recommended
  - Smokers have Adempas levels that are 50-60% lower than non-smokers
  - Safety and efficacy have not been demonstrated in individual with a CrCl < 15 mL/min or on dialysis
  - Safety and efficacy have not been demonstrated in individual with severe hepatic impairment (Child-Pugh class C)
  - Woman who is breast feeding an infant or child should stop breast feeding
  - Strong CYP3A4 inducers may decrease Adempas levels, however a guide for dosing is not available
  - Aluminum containing antacids should not be taken within 1 hours of taking Adempas

- Orenitram (treprostinil)
  - Doses should not be abruptly discontinued, decrease the dose in steps of 0.5-1 mg per day
  - In patients with mild hepatic impairment (Child-Pugh Class A), the starting dose should be 0.125 mg twice daily, increase by 0.125 mg twice daily every 3-4 days
  - Avoid use in moderate hepatic impairment (Child-Pugh class B)
  - In patients also using strong CYP2C8 inhibitors (gemfibrozil), the starting dose should be 0.125 mg twice daily, increase by 0.125 mg twice daily every 3-4 days
  - Treprostinil inhibits platelet aggregation and increases the risk of bleeding
  - Woman breast feeding an infant or child should stop breast feeding
  - The absolute bioavailability if Orenitram is 17%

## ADEMPAS® (riociguat) oral tablet
## ORENITRAM™ (treprostinil ER) oral tablet (cont.)

**Criteria:**

- **Criteria for initial therapy:** Adempas (riociguat) and Orenitram (treprostinil) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

1. Prescriber is a pulmonologist specializing in treating patients with PAH

2. Individual is 18 years of age or older

3. **For Adempas**: A confirmed diagnosis of **ONE** of the following:
   - Persistent or recurrent Chronic Thromboembolic Pulmonary Hypertension (CTEPH, WHO group 4) to improve exercise capacity and WHO functional class in individuals who are **EITHER** of the following:
     - After surgical treatment for CTEPH
     - Inoperable candidate
   - Pulmonary arterial hypertension (PAH, WHO group 1) to improve exercise capacity, improve WHO functional class and to delay clinical worsening

4. **For Orenitram**: A confirmed diagnosis of pulmonary arterial hypertension (PAH, WHO group 1), with Functional Class II or III symptoms, to improve exercise capacity (WHO Group and Functional Class category must be submitted with request)

5. Right heart catheterization documents **ALL** of the following:
   - Mean pulmonary artery pressure > 25 mm Hg at rest
   - pulmonary arterial wedge pressure ≤ 15 mm Hg
   - pulmonary vascular resistance > 3 Wood units

6. Vasoreactivity testing with negative results

7. Chronic lung diseases and other causes of hypoxemia are mild or absent

8. **For Orenitram**: Venous thromboembolic disease is absent

9. Individual does not have other disorders, that would put them into WHO group 5 PH, including:
   - systemic disorders (e.g., sarcoidosis),
   - hematologic disorders (e.g., myeloproliferative diseases), and
   - metabolic disorders (e.g., glycogen storage disease)

10. Individual has failure, intolerance, or contraindication to oral generic sildenafil

11. **For Orenitram**: Individual has failure, intolerance, or contraindication to use **ONE** oral Endothelin Receptor Antagonist (ambrisentan, bosentan, macitentan) **OR** riociguat

12. There are **NO** contraindications
    - Contraindications include:

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- **For Adempas**:
  - Use of any type of Phosphodiesterase Inhibitor (this includes PDE5 inhibitors, Dipyridamole or Theophylline)
  - Use of nitrates or nitric oxide donors (such as amyl nitrite) in any form
  - Pulmonary hypertension associated with idiopathic interstitial pneumonias (PH-IIP)
- **For Orenitram**:
  - Severe hepatic impairment (Child-Pugh class C)

**Initial approval duration**: 12 months

- **Criteria for continuation of coverage (renewal request):** Adempas (riociguat) and Orenitram (treprostinil) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

1. Individual continues to be seen by a pulmonologist specializing in treating patients with PAH

2. Monitor patient for disease status:
   - Reduction in hospitalizations for PAH
   - 6-minute walking distance (6MWD)
   - Functional Class symptoms

3. Individual has been adherent with the medication

4. Individual has not developed any contraindications or other significant level 4 drug effects that may exclude continued use
   - Contraindications as listed in the criteria for initial therapy section
   - Significant adverse effect such as:
     - Pulmonary veno-occlusive disease due to Adempas
     - Liver toxicity

5. There are no significant interacting drugs

**Renewal duration**: 12 months

**Resources:**

Adempas. Package Insert. Revised by manufacturer 01/2018. Accessed 02-23-2018

Adempas. Package Insert. Revised by manufacturer 10/2013. Accessed 04-11-2014.

Adempas. Package Insert. Revised by manufacturer 02/2017. Accessed 03-04-2017.

## ADEMPAS® (riociguat) oral tablet
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Orenitram. Package Insert. Revised by manufacturer 12/2013. Accessed 06-17-2014.

Orenitram. Package Insert. Revised by manufacturer 01/2016. Accessed 03-17-2016.

Orenitram. Package Insert. Revised by manufacturer 01/2017. Accessed 03-05-2017, 02-23-2018

Taichman DB, Ornelas J, Chung L, et al.: Pharmacologic Therapy for Pulmonary Arterial Hypertension in Adults. CHEST Guideline and Expert Panel Report. 2014 Chest; 146(2):449-475.

Galie N, Humbert M, Vachiery JL, et al.: 2015 ESC/ERS Guidelines for the diagnosis and treatment of pulmonary hypertension. The Joint Task Force for the Diagnosis and Treatment of Pulmonary Hypertension of the European Society of Cardiology (ESC) and the European Respiratory Society (ERS). 2016 Eur Heart J; 37:67-119.

UpToDate: Classification and prognosis of pulmonary hypertension in adults. Current through Jan 2018. https://www-uptodate-com.mwu.idm.oclc.org/contents/classification-and-prognosis-of-pulmonary-hypertension-in-adults?search=pulmonary%20hypertension&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1

UpToDate: Clinical feature and diagnosis of pulmonary hypertension in adults. Current through Jan 2018. https://www-uptodate-com.mwu.idm.oclc.org/contents/clinical-features-and-diagnosis-of-pulmonary-hypertension-in-adults?search=pulmonary%20hypertension&source=search_result&selectedTitle=2~150&usage_type=default&display_rank=2

UpToDate: Treatment of pulmonary hypertension in adults. Current through Jan 2018. https://www-uptodate-com.mwu.idm.oclc.org/contents/treatment-of-pulmonary-hypertension-in-adults?search=pulmonary%20hypertension&source=search_result&selectedTitle=3~150&usage_type=default&display_rank=3#H5

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**Fax completed prior authorization request form to 602-864-3126** or email to pharmacyprecert@azblue.com.
Call 866-325-1794 to check the status of a request.
All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned.**
Pharmacy Coverage Guidelines are available at www.azblue.com/pharmacy.

# Pharmacy Prior Authorization Request Form

**Do not copy for future use. Forms are updated frequently.**
**REQUIRED: Office notes, labs, and medical testing relevant to the request that show medical justification are required.**

## Member Information

| Member Name (first & last): | Date of Birth: | Gender: | BCBSAZ ID#: |
|---|---|---|---|
| Address: | City: | State: | Zip Code: |

## Prescribing Provider Information

| Provider Name (first & last): | Specialty: | NPI#: | DEA#: |
|---|---|---|---|
| Office Address: | City: | State: | Zip Code: |
| Office Contact: | Office Phone: | Office Fax: | |

## Dispensing Pharmacy Information

| Pharmacy Name: | Pharmacy Phone: | Pharmacy Fax: |
|---|---|---|

## Requested Medication Information

| Medication Name: | Strength: | Dosage Form: |
|---|---|---|
| Directions for Use: | Quantity: / Refills: | Duration of Therapy/Use: |

☐ Check if requesting **brand** only ☐ Check if requesting **generic**

☐ Check if requesting continuation of therapy (prior authorization approved by BCBSAZ expired)

## Turn-Around Time For Review

☐ Standard ☐ Urgent. Sign here: _____ ☐ Exigent (requires prescriber to include a written statement)

## Clinical Information

1. **What is the diagnosis? Please specify below.**

   **ICD-10 Code:** _____ **Diagnosis Description:** _____

2. ☐ Yes ☐ No **Was this medication started on a recent hospital discharge or emergency room visit?**

3. ☐ Yes ☐ No **There is absence of ALL contraindications.**

4. **What medication(s) has the individual tried and failed for this diagnosis? Please specify below.**
Important note: Samples provided by the provider are not accepted as continuation of therapy or as an adequate trial and failure.

| Medication Name, Strength, Frequency | Dates started and stopped or Approximate Duration | Describe response, reason for failure, or allergy |
|---|---|---|
| | | |
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| | | |
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5. **Are there any supporting labs or test results? Please specify below.**

| Date | Test | Value |
|---|---|---|
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# Pharmacy Prior Authorization Request Form

**6. Is there any additional information the prescribing provider feels is important to this review? Please specify below.**
For example, explain the negative impact on medical condition, safety issue, reason formulary agent is not suitable to a specific medical condition, expected adverse clinical outcome from use of formulary agent, or reason different dosage form or dose is needed.

**Signature affirms that information given on this form is true and accurate and reflects office notes**

Prescribing Provider's Signature: Date:

**Please note**: Some medications may require completion of a drug-specific request form.

**Incomplete forms or forms without the chart notes will be returned.**

Office notes, labs, and medical testing relevant to the request that show medical justification are required.