OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Adempas® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength: Dosage Form:
❑ Check if requesting **brand**	Directions for Use:
❑ Check if request is for **continuation of therapy**	

Clinical Information (required)

Select the diagnosis below:
- ❑ Chronic thromboembolic pulmonary hypertension (CTEPH)
- ❑ Pulmonary arterial hypertension (PAH)
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Provider's Specialty:
Is the requested medication prescribed by or in consultation with a pulmonologist or cardiologist? ❑ **Yes** ❑ **No**

For chronic thromboembolic pulmonary hypertension (CTEPH), answer the following:
Does the patient have inoperable or persistent/recurrent CTEPH? ❑ **Yes** ❑ **No**
Does the patient have CTEPH that is symptomatic? ❑ **Yes** ❑ **No**
Is the patient currently on any therapy for the diagnosis of CTEPH? ❑ **Yes** ❑ **No**

For pulmonary arterial hypertension (PAH), answer the following:
Does the patient have PAH that is symptomatic? ❑ **Yes** ❑ **No**
Was the diagnosis of PAH confirmed by right heart catheterization? ❑ **Yes** ❑ **No**
Is the patient currently on any therapy for the diagnosis of PAH? ❑ **Yes** ❑ **No**

Reauthorization:
If this is a reauthorization request, answer the following question:
Is there documentation the patient has had a positive clinical response to therapy? ❑ **Yes** ❑ **No**

Quantity Limit Requests:
What is the quantity requested per DAY? _____
What is the reason for exceeding the plan limitations?
- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Adempas_Comm_2017Jun-W