Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Bosentan - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is bosentan being prescribed by or in consultation with a cardiologist or pulmonologist?

☐ Yes ☐ No

Q2. Is the patient between 3 to 15 years of age?

☐ Yes ☐ No

Q3. Is the patient 15 years of age or older?

☐ Yes ☐ No

Q4. Is the patient a female?

☐ Yes ☐ No

Q5. Is the patient pregnant?

☐ Yes ☐ No

Q6. Is the patient able to get pregnant?

☐ Yes ☐ No

Q7. Will the patient use reliable forms of contraception?

☐ Yes ☐ No

Q8. Will the patient have pregnancy tests before therapy initiated and monthly during therapy?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q9. Does the patient have the diagnosis of World Health Organization (WHO) Group 1 pulmonary arterial hypertension (PAH)?

☐ Yes ☐ No

Q10. Has the diagnosis of PAH been confirmed by a complete right heart catheterization (RHC) (please attach RHC report)? PAH defined as: A. A mean pulmonary artery pressure (mPAP) greater than 20 mmHg; B. A pulmonary capillary wedge Pressure/ left atrial pressure/left ventricular end-diastolic pressure (PCWP/LAP/LVEDP) less than or equal to 15 mmHg; C. A pulmonary vascular resistance (PVR) greater than 3 Wood units.

☐ Yes ☐ No

Q11. Does the patient have the diagnosis of idiopathic or congenital PAH, confirmed by mPAP of greater than or equal to 20 mmHg?

☐ Yes ☐ No

Q12. Does the patient have any other contraindication to bosentan? Please refer to the following: A. Use with Cyclosporine A; B. Use with Glyburide

☐ Yes ☐ No

Q13. Will serum transaminase (AST and ALT) and bilirubin be monitored prior to initiation of treatment and then monthly?

☐ Yes ☐ No

Q14. Requested Duration:

☐ 12 months

Q15. Additional Information:

Prescriber Signature

Date

2023 Medicare Prior Authorization Request