US Family Health Plan
Prior Authorization Request Form for
riociguat **(Adempas)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

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 a pulmonologist?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Is the patient taking PDE-5 inhibitors or nitrate drugs at the same time? *(for example, amyl nitrite, BiDil, Dilatrate-SR, IsoDitrate ER, Isordil, isosorbide dinitrate, isosorbide mononitrate, Nitro-Bid, Nitro-Dur, nitroglycerin, Nitrolingual, NitroMist, Nitrostat, Nitro-Time, Rectiv)*	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **3**
3. Does the patient have a documented diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH) WHO Group 4 PAH?	☐ Yes **Sign and date below**	☐ No Proceed to question **4**
4. Does the patient have a documented diagnosis of WHO group 1 PAH?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. Has the patient had a right heart catheterization?	☐ Yes Proceed to question **6**	☐ No **STOP** Coverage not approved
6. 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 **7**	☐ No **STOP** Coverage not approved

7. Did the results of the right heart catheterization confirm the diagnosis of WHO Group 1 PAH?	☐ Yes Proceed to question **8**	☐ No **STOP** Coverage not approved
8. Has the patient had an adequate trial of sildenafil 20 mg (brand Revatio, generics) and failed or did not respond to therapy?	☐ Yes Proceed to question **9**	☐ No **STOP** Coverage not approved
9. Has the patient had an adequate trial of tadalafil 40 mg (Adcirca, generics) and failed or did not respond to therapy?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____