US FamilyHealth Plan
Prior Authorization Request Form for
bosentan (**Tracleer**)

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 pulmonologist?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. What is the indication or diagnosis?	☐ WHO group 1 - Proceed to question **3** ☐ WHO group 4 - Proceed to question **6** ☐ Other indication or diagnosis – **STOP Coverage not approved**	
3. Has the patient had a right heart catheterization?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. 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 **5**	☐ No **STOP** **Coverage not approved**
5. Did the results of the right heart catheterization confirm the diagnosis of WHO Group 1?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
6. Has the patient tried Adempas or have a contraindication to Adempas?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

Continue on next page

7. Is the patient and provider enrolled in the Tracleer REMS program?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **9**
9. Is the patient a women of childbearing potential?	☐ Yes Proceed to question **10**	☐ No Proceed to question **11**
10. Is adequate contraception being used?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Does the patient have baseline elevated aminotransferases greater than three times the upper limit of normal due to difficulty in monitoring for hepatotoxicity?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **12**
12. Does the patient have moderate or severe liver impairment (for example, Child-Pugh Class B or C)?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3

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

_____ _____

Prescriber Signature Date