Prescriber Criteria Form

Ambrisentan 2025 PA Fax 640-A v1 010125.docx
Letairis (ambrisentan)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Letairis (ambrisentan).

Drug Name:
Letairis (ambrisentan)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1)? [If no, then no further questions.]	Yes ◯	No ◯
2	Has pulmonary arterial hypertension (PAH) been confirmed by right heart catheterization? [If no, then no further questions.]	Yes ◯	No ◯
3	Has the patient previously received the requested drug for pulmonary arterial hypertension (PAH)? [If yes, then no further questions.]	Yes ◯	No ◯
4	Does the patient meet all of the following criteria: A) pretreatment mean pulmonary arterial pressure greater than 20 millimeters of mercury (mmHg), B) pretreatment pulmonary capillary wedge pressure less than or equal to 15 millimeters of mercury (mmHg), C) pretreatment pulmonary vascular resistance greater than or equal to 3 Wood units?	Yes ◯	No ◯

Comments:	

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____