

Prescriber Criteria Form

Tracleer 2025 PA Fax 234-A v2 010125.docx  
 Tracleer (bosentan)  
 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 Tracleer (bosentan).

Drug Name:  
 Tracleer (bosentan)

<b>Patient Name:</b>		
<b>Patient ID:</b>		
<b>Patient DOB:</b>	<b>Patient Phone:</b>	
<b>Prescriber Name:</b>		
<b>Prescriber Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Prescriber Phone:</b>	<b>Prescriber Fax:</b>	
<b>Diagnosis:</b>	<b>ICD Code(s):</b>	

<b>Please circle the appropriate answer for each question.</b>			
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 have 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)? [If no, then no further questions.]	Yes	No
5	Is the request for an adult patient? [If no, then no further questions.]	Yes	No
6	Does the patient have a pretreatment pulmonary vascular resistance greater than or equal to 3 Wood units? [If no, then no further questions.]	Yes	No

7	Has the patient experienced an inadequate treatment response, intolerance, or the patient has a contraindication to ambrisentan (Letairis)?	Yes	No
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Comments:	
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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.

<b>Prescriber (or Authorized) Signature:</b> _____ <b>Date:</b> _____
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