



Tracleer® (bosentan) Prior Authorization Request Form

Please fax the completed request form to Mercy Health Plans' Pharmacy Department at 314-214-8201 or 800-466-9854. For additional information call 314-214-8282 or 800-647-2240.

Patient Name: _____ Today's Date: ____/____/____
 Patient Pharmacy ID: _____ Date of Birth: ____/____/____
(located on bottom right of insurance card)
 Requesting Physician: _____ Specialty: _____
(Please print)
 Office Contact Person: _____ Phone #: __ (____) ____ - ____ ext ____
 Medication/dose Requested: _____ Fax #: __ (____) ____ - ____
 Expected Duration of Therapy: _____ ICD-9 _____

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|--|-----|----|
| 1. Does the patient have a diagnosis of primary pulmonary hypertension (PPH)? | YES | NO |
| 2. Does the patient have a diagnosis of secondary pulmonary hypertension associated with Scleroderma or lupus? | YES | NO |
| 3. Is the patient currently taking Cyclosporine? | YES | NO |
| 4. Is the patient currently taking Glyburide? | YES | NO |
| 5. Does the patient have WHO Class III or IV symptoms? | YES | NO |

WHO Classification of Functional Status of Patients with Pulmonary Hypertension	
Class	Description
I	Patients with PH in whom there is no limitation of usual physical activity; ordinary physical activity does not cause increased dyspnea, fatigue, chest pain, or presyncope.
II	Patients with PH who have mild limitation of physical activity. There is no discomfort at rest, but normal physical activity causes increased dyspnea, fatigue, chest pain, or presyncope.
III	Patients with PH who have a marked limitation of physical activity. There is no discomfort at rest, but less than ordinary activity causes increased dyspnea, fatigue, chest pain, or presyncope.
IV	Patients with PH who are unable to perform any physical activity at rest and who may have signs of right ventricular failure. Dyspnea and/or fatigue may be present at rest, and symptoms are increased by almost any physical activity.

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| 6. Has the patient previously failed a trial of a calcium channel blocker (CCB) or are CCBs contraindicated?
Reason for failure or contraindication: _____ | YES | NO |
| 7. Is the patient female? | YES | NO |
| 8. Will the patient be monitored for pregnancy prior to initiation and during therapy? | YES | NO |
| 9. Will the patient have liver function and bilirubin tests prior to initiation and regular monitoring throughout therapy? | YES | NO |

Physician's Signature: _____ Date: ____/____/____

For Mercy Health Plans use only:	Approved	Length of Approval _____
Denied	Reason for Denial _____	
Reviewer's Signature: _____	Date Reviewed: ____/____/____	
Override Entered in Caremark CCMS for _____ - _____	by _____	
Office Notified on _____	at _____ am/pm; by _____	spoke to _____