Initial Approval: April 10, 2013
Revised Dates: April 13, 2016
April 9, 2014; January 8, 2014

CRITERIA FOR PRIOR AUTHORIZATION

Pulmonary Arterial Hypertension Agents

PROVIDER GROUP Pharmacy
Professional

MANUAL GUIDELINES The following drug(s) require prior authorization:
Ambrisentan Tablets (Letairis©)
Bosentan Tablets (Tracleer ©)
Epoprostenol Injection (Flolan©, Veletri©)
Iloprost Inhalation Solution (Ventavis®)
Macitentan (Opsumit®)
Riociguat (Adempas®)
Sildenafil Tablets, Oral Suspension, and Injection (Revatio©)
Treprostinil Extended-Release Tablets (Orenitram®)
Treprostinil Inhalation Solution (Tyvaso®)
Treprostinil Injection (Remodulin©)
Tadalafil Tablets (Adcirca ©)
Selexipag (Uptravi®)

CRITERIA FOR APPROVAL (ALL AGENTS, EXCEPT ADEMPAS): (must meet all of the following)

- Patient must have a diagnosis of pulmonary arterial hypertension (PAH)
- Must be prescribed by or in consultation with a pulmonologist, cardiologist, or specialized treatment center

LENGTH OF APPROVAL 12 months

CRITERIA FOR APPROVAL (ADEMPAS ONLY): (must meet all of the following)

- Patient must have a diagnosis of pulmonary arterial hypertension (PAH) **OR** chronic thromboembolic pulmonary hypertension (CTEPH)
- Must be prescribed by or in consultation with a pulmonologist, cardiologist, or specialized treatment center

LENGTH OF APPROVAL 12 months