

**Blue Cross Blue Shield of Vermont and The Vermont Health Plan
Prior Approval Form
Letairis™ (ambrisentan)
BCBSVT and TVHP Fax # (888)–255-1006**

If approval criteria are met BCBSVT/TVHP will authorize coverage of Letairis (ambrisentan). Thank you for your assistance.

PLEASE COMPLETE THE FOLLOWING SECTIONS:

Date of Request _____ Patient Name: _____
 BCBSVT/TVHP Member ID#: _____ Date of birth: _____
 Provider Name: _____ Provider Phone number: _____
 Provider Fax number: _____ PCP Name: _____

INDICATIONS FOR USE	<u>YES</u>	<u>NO</u>
1) Is patient eighteen years of age or greater?	<input type="checkbox"/>	<input type="checkbox"/>
2) Does patient have a diagnosis of Pulmonary Artery Hypertension?	<input type="checkbox"/>	<input type="checkbox"/>
3) Does patient have WHO Class II PAH symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
4) Does patient have WHO Class III PAH symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
5) Is patient pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
6) Does Patient have moderate or severe liver disease?	<input type="checkbox"/>	<input type="checkbox"/>
7) Is patient concurrently taking Cyclosporin A?	<input type="checkbox"/>	<input type="checkbox"/>

Dose: _____ Frequency: _____ Duration of Therapy: _____

References

1. Package Insert Letairis™, Gilead Sciences, Inc. Foster City, CA 94404

PRESCRIBER SIGNATURE _____ DATE _____

By signing above, the prescriber confirms all information provided is accurate and verifiable via member records.

