



Date of Request: _____

Sterling Retiree Rx Prior Authorization Form

LETAIRIS (Ambrisentan)

Coverage Criteria / Required Medical Information

Diagnosis of Pulmonary Arterial Hypertension (PAH), (WHO Group 1). NYHA class II or III symptoms. PAH been confirmed by right heart catheterization. If patient is an infant, PAH diagnosed by Doppler echocardiogram.

For women of childbearing potential: IUD or two appropriate contraceptive methods.

Exclusion Criteria:

AST/ALT level > 3 times ULN; pregnancy for females

Member Information

Name					
Enrollment/Card-holder ID Number					
Group/Plan		Male		Female	
Date of Birth		Age		Weight in Kg	
Street Address					
City		State		Zip	

Physician Information

Name					
Agent		Contact Name			
Specialty/Office					
Clinic Name					
Street Address					
City		State		Zip	
Phone		Fax			

Requested Drug

LETAIRIS		Reason for Request			
Condition/Diagnosis Related					

Clinical Drug/Lab History Pertinent to Request

Labs: Baseline/Ongoing			Strength/Dosage		
Formulary Alternative(s) Attempted?					
Yes:			No:		
Please List Alternative Formulary Drugs					

Comments

Physician Signature: _____ Fax Form to 1-866-481-3704