Prescriber Criteria Form Adempas 2024 PA Fax 1048-A v1 010124.docx Adempas (riociguat) 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 Adempas (riociguat).

Drug Name: Adempas (riociguat)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH) (World Health Organization [WHO] Group 4)? [If no, then skip to question 5.]	Yes	No
2	Does the patient have persistent or recurrent chronic thromboembolic pulmonary hypertension (CTEPH) after pulmonary endarterectomy (PEA)? [If yes, then no further questions.]	Yes	No
3	Does the patient have inoperable chronic thromboembolic pulmonary hypertension (CTEPH)? [If no, then no further questions.]	Yes	No
4	Has chronic thromboembolic pulmonary hypertension (CTEPH) been confirmed by both of the following tests: A) right heart catheterization, B) computed tomography (CT), magnetic resonance imaging (MRI), or pulmonary angiography? [No further questions.]	Yes	No
5	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
6	Has pulmonary arterial hypertension (PAH) been confirmed by right heart catheterization? [If no, then no further questions.]	Yes	No

7	Has the patient previously received the requested drug? [If yes, then no further questions.]	Yes	No
8	Does the patient meet 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 mmHg, C) pretreatment pulmonary vascular resistance greater than or equal to 3 Wood units?	Yes	No

Comments:	_____

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.

Prescriber (or Authorized) Signature: _____ **Date:**_____