Send completed form to:
Blue Shield of California
Fax: 1-855-895-3504

Adempas
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form. All incomplete and illegible forms will be returned to the patient.

CARDHOLDER / PATIENT INFORMATION

Cardholder Name: ______________________ / _____ / ______________________
First MI Last

Patient Name: ______________________ / _____ / ______________________
First MI Last

Patient Address: ____
Street City State Zip

Patient Date of Birth: ___ / ___ / ___ Sex: M ____ F _____

R [| | | | | | |]
Cardholder Identification Number

PHYSICIAN COMPLETES

Adempas (riociguat)

NOTE: Form must be completed in its **entirety** for processing

1. What is the patient's **diagnosis?**
   - ☐ **Pulmonary Arterial Hypertension (PAH), also known as familial or idiopathic - WHO Group 1**
   - ☐ **Pulmonary Hypertension** (*please select the cause of Pulmonary Hypertension below*):
     - ☐ Collagen vascular disease
     - ☐ Pulmonary-capillary hemangiomatosis
     - ☐ Hereditary hemorrhagic telangiectasia
     - ☐ Pulmonary veno-occlusive disease
     - ☐ Left heart disease (WHO Group II)
     - ☐ Hemoglobinopathies
     - ☐ Congenital systemic-to-pulmonary shunts
     - ☐ Lung disease (WHO Group III)
     - ☐ Exposure to drugs/toxins
     - ☐ Glycogen storage disease
     - ☐ Myeloproliferative disorder
     - ☐ Other cause *(please specify)*: ______________________
     - ☐ HIV infection
     - ☐ Splenectomy
     - ☐ Thyroid disorder
     - ☐ Gaucher's disease
     - ☐ Portal hypertension
   - ☐ **Chronic Thromboembolic Pulmonary Hypertension (CTEPH) - WHO Group IV**
     - a. Is the patient's CTEPH persistent / recurrent? ☐ Yes ☐ No
     - b. Has the patient had prior surgical treatment or was the CTEPH deemed inoperable? ☐ Yes ☐ No
   - ☐ **Other Diagnosis** *(please specify)*: ______________________
2. What level of physical activity causes shortness of breath or fatigue? ***(please select one of the following)***:
   - ☐ No symptoms and no limitations in ordinary physical activity (Class I)
   - ☐ Mild symptoms and slight limitation during ordinary activity (Class II)
   - ☐ Marked limitation in activity due to symptoms, even during less than ordinary activity (Class III)
   - ☐ Experiences shortness of breath and fatigue while at rest (Class IV)
3. Will the patient be concurrently using nitrate medications (in any form)? ☐ Yes ☐ No
4. Will the patient be taking concurrent therapy with nitric oxide donors? ☐ Yes ☐ No
5. Will the patient be taking concurrent therapy with phosphodiesterase inhibitors? ☐ Yes ☐ No
6. Please answer the following two questions if the patient is **female:**
   - a. Are both patient and prescriber enrolled in the Adempas REMS program? ☐ Yes ☐ No
   - b. If the patient is of childbearing potential, has pregnancy been excluded before the initiation of treatment? ☐ Yes ☐ No ☐ N/A, patient is not of childbearing potential

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification.
Prescriber Certification: I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer.

______________________ (____) ______________ (____) ______________
Physician Name (Print Clearly) Phone Fax

______________________ ______________ ________ ________
Street Address City State Zip

______________ ______________________ ____ / ____ / ____
Prescriber's NPI Physician Signature Date