TRACLEER Prescription and Statement of Medical Necessity (PSMN)

Complete this form for ALL patients.
Fax this completed form along with the TRACLEER Patient Consent and Enrollment form and copies of all insurance cards (front and back) to 1-866-279-0669.
Contact *Actelion Pathways*® at 1-866-228-3546 for questions.

1 Patient Information (please print)

★ **(REQUIRED)** First name

★ **(REQUIRED)** Last name

★ **(REQUIRED)** Birth date

★ ☐ Male ☐ Female **(REQUIRED)** Gender

Address

City

State

ZIP

★ **(REQUIRED)** Primary phone #

Alternate phone #

Primary language

Best time to call

2 Prescriber Information (please print)

First name

Last name

Specialty

Practice name

Address

City

State

ZIP

Office contact

Email address

Prescriber NPI

Prescriber Tax ID

Certified pharmacy preference (If left blank, this referral will be sent to the appropriate certified pharmacy based on the patient's existing benefits.)

3 Diagnostic Testing (please print)

Is patient diagnosed with pulmonary arterial hypertension (PAH, World Health Organization [WHO, Group 1]), defined as mean pulmonary arterial pressure ≥25 mmHg, pulmonary arterial wedge pressure ≤15 mmHg, and pulmonary vascular resistance >3 Wood units? ☐ Yes ☐ No

Is request submitted by, or under the recommendation of, a pulmonologist or cardiologist? ☐ Yes ☐ No

Right heart catheterization (RHC)

Mean pulmonary artery pressure (mPAP) _____ mmHg

Pulmonary arterial wedge pressure (PAWP) _____ mmHg

Pulmonary vascular resistance (PVR) _____ mmHg

Acute vasoreactivity testing (CHECK ONE BOX)

☐ Patient responded

☐ Patient did not respond

Date of test

Additional test results

Functional class

Echocardiography (See enclosed test results) — Date

6-minute walk distance (6MWD) — Date

6-minute walk distance (6MWD) — Date

4 Current and Past Treatments (please print)

Past treatment — Reason for discontinuation

Past treatment — Reason for discontinuation

Current treatment(s)

Current specialty pharmacies

5 *Actelion Pathways* Services Authorization

I authorize my healthcare providers, pharmacies, health plans, or payers ("my healthcare organizations") to share personal and health information about me related to my Actelion therapies ("my information") with Actelion Pharmaceuticals US, Inc., its affiliates, agents, and contractors (collectively, "Actelion"). I understand that once my information is shared with Actelion, my information may be protected by certain state privacy laws but not by federal health privacy laws, and may be redisclosed by Actelion. Actelion agrees to protect my information and to use and share it only for the reasons listed below. I understand that my pharmacy may receive compensation in connection with sharing my information with Actelion as allowed under this Authorization. I authorize my healthcare organizations to share my information with Actelion, in order for Actelion to: (1) contact me or my healthcare organizations, or others I have identified, about my disease or treatment; (2) confirm my health plan eligibility and benefits, identify other payers for my therapy, or determine whether I may be eligible for assistance programs; (3) enroll me in Actelion PAH therapies-related programs and provide therapy access support services; (4) perform analyses or improve or develop products, services, programs, or treatment related to my disease; (5) provide me by any means of communication, including by e-mail, mail, or telephone (including voicemail), with information to educate or inform me about Actelion PAH therapies and ways to help me maintain my prescribed treatment; and (6) use and disclose my information for safety reasons or as required by law. I understand that if I do not sign this form, I will still be eligible for health plan benefits and my treatment and payment for my treatment by my healthcare providers and pharmacy will not be affected, but I will not have access to the Actelion services and support described above. This Authorization will expire in 10 years from the date signed below unless a shorter period is required by the law of my state of residence. I may discuss the scope of my Authorization at any time by calling 1-866-875-0277 and may cancel it by writing a letter saying I cancel my Authorization, and mailing it to Actelion Pharmaceuticals US, Inc.: PO Box 826, South San Francisco, CA 94083. My cancellation will not be effective until after Actelion receives it and my healthcare organizations are notified of it by Actelion, and it will not apply to prior actions taken by Actelion and my healthcare organizations based on this Authorization. I have a right to request and receive a copy of this Authorization in the same ways described above for cancellation.

(FOR ALL PATIENTS) Patient or Parent/Guardian Signature — Date

Please Complete Additional Fields on the Following Page ▶

Patient name

6 Prescription and Shipping Information (please print)

★ ☐ ICD-9 416.0/ICD-10 127.0 Primary pulmonary hypertension ☐ ICD-9 416.8/ICD-10 127.2 Other secondary pulmonary hypertension

★ **Pulmonary arterial hypertension (PAH)**

- ☐ Idiopathic PAH
- ☐ Connective tissue disorder
- ☐ Heritable PAH
- ☐ Congenital heart disease
- ☐ Other _____

_____

★ **TRACLEER** (bosentan) dosing: 62.5 and 125 mg tablets
Directions for use and dispensing instructions: Complete A or B below

A. ☐ Sig: Take 62.5 mg tablet by mouth twice daily x 4 weeks, then increase to the maintenance dose of 125 mg tablet by mouth twice daily.
Disp: TRACLEER 62.5 mg tablets (66215-101-06) (60 tablets). No refills.
TRACLEER 125 mg tablets (66215-102-06) (60 tablets). Refill x 11.

OR

B. ☐ Sig: _____

_____

Disp: TRACLEER 62.5 mg tablets (66215-101-06)_____(Qty) tablets

Refill x _____.

TRACLEER 125 mg tablets (66215-102-06)_____(Qty) tablets

Refill x _____.

★ **Ship to:**

- ☐ Patient home
- ☐ Prescriber office
- ☐ Other—Please specify address if different than patient home or prescriber office.

_____
Address

_____

_____

_____
City

_____ _____
State ZIP

7 Statement of Medical Necessity

I have made the determination, based on my independent clinical judgment, that the medication ordered on the front is medically necessary for the patient for the intended use. I am personally supervising the care of this patient. I authorize Actelion Pharmaceuticals US, Inc., its affiliates, agents, and contractors (collectively, "Actelion") to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan. This authorization includes permitting Actelion to communicate to payers on my behalf to confirm this patient's health plan eligibility and benefits. **PHYSICIAN SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS. Physician attests this is his/her legal signature (NO STAMPS). Prescriptions must be faxed.**

★ _____ _____
Physician's signature (Dispense as written) Date

★ _____ _____
Physician's signature (Substitution allowed) Date

The physician is to comply with their state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.

8 Insurance Information (please print)

☐ Insurance card and/or prescription card attached

_____ _____
Primary insurance Subscriber name

_____ _____
Name of insured Policy #

_____ _____
Group # Phone #

_____ _____
Secondary insurance Subscriber name

_____ _____
Name of insured Policy #

_____ _____
Group # Phone #

9 Fax Requirements

Fax these completed forms and copies of all insurance cards to 1-866-279-0669.

- **This TRACLEER Prescription and Statement of Medical Necessity (PSMN) form** (page 1 and 2)
- **TRACLEER Patient Consent and Enrollment form** (front and back)
- **Prior authorization (PA) form, signed and dated**
- **Insurance cards** (front and back)