



**BlueCross BlueShield  
of North Carolina**

**ORAL DRUGS FOR PULMONARY ARTERIAL HYPERTENSION (PAH)  
PRIOR REVIEW/CERTIFICATION FAXBACK FORM**

**BOSENTAN (Tracleer<sup>®</sup>), AMBRISENTAN (Letairis<sup>®</sup>),  
SILDENAFIL (Revatio<sup>®</sup>), TADALAFIL (Adcirca<sup>®</sup>)**

**INCOMPLETE FORMS MAY DELAY PROCESSING  
ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT BCBSNC PROVIDER ID# BELOW**

PRESCRIBER INFORMATION		PATIENT INFORMATION	
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME	
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID	
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH	
PRACTICE ADDRESS	CITY	STATE	ZIP

**Drug Requested:** \_\_\_\_\_ **Dx Code:** \_\_\_\_\_

**Please answer the following questions:**

1. Is this patient currently receiving the requested drug? .....  Yes  No

2. Does the patient have a confirmed diagnosis of pulmonary arterial hypertension  
(PAH/WHO Group I) that is symptomatic? .....  Yes  No

**If this request is for SILDENAFIL (Revatio) or TADALAFIL (Adcirca):**

3. Is the patient taking concurrent nitroglycerin or other nitrate therapy in any form? .....  Yes  No

4. Is this drug being used to treat sexual dysfunction? .....  Yes  No

**Please certify the following by signing and dating below:**

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required): \_\_\_\_\_ Date: \_\_\_\_\_

**For BCBSNC members, fax form to 1-800-795-9403**