

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

**TRACLEER** (bosentan)

Patient name: \_\_\_\_\_ Medicaid or SS# \_\_\_\_\_

Physician Name: \_\_\_\_\_ Contact person: \_\_\_\_\_

Phone#: \_\_\_\_\_ Extensions and options \_\_\_\_\_ Fax# \_\_\_\_\_

Pharmacy \_\_\_\_\_ Pharmacy Phone#: \_\_\_\_\_

**All information to be legible, complete and correct or form will be returned**

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**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF  
MEDICAL NECESSITY TO (801) 536-0477**

**CRITERIA:**

- ▶ Age limit: 13 and above
- ▶ Documented WHO (World Health Organization) diagnosis of class III or IV Pulmonary Arterial Hypertension
- ▶ Copy of prescription from physician.

**AUTHORIZATION:**

1 year

**RE-AUTHORIZATION:**

Telephone request from physician's office or pharmacy.

**INFORMATION:**

- ▶ Contraindicated for patients with moderate to severe liver impairment and patients taking cyclosporine or glyburide
- ▶ Females can not be capable of becoming pregnant.
- ▶ Dose: 62.5mg b.i.d. for 4 weeks, then increased to 125mg b.i.d. (Maximum)