

Health New England
Medication Request Form (MRF) /Prescription Request
Tracleer® (Bosentan)

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Prior Authorization

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Tracleer®. Please complete this form and fax to MedMetrics Health Partners at (800) 550-9246. If you have any questions regarding this process, please contact MedMetrics clinical call center at (866) 209-1057.

Medication Request Information (please complete each section of this form prior to transmittal):

Patient Information (all required)	Physician Information (all required)
Patient Name:	Physician Name:
	Specialty:
Patient Cell Phone #: () -	NPI #:
Patient HNE ID#:	HNE Provider #:
Patient Date of Birth:	DEA #:
Allergies:	Telephone #: () -
	Fax #: () -

Drug Information		
Requested Drug/Strength/Form: Tracleer®		
ONLY AVAILABLE THROUGH TRACLEER ACCESS PROGRAM		
Dose, Directions, and length of treatment (please be specific):	Quantity (60 tablets/month maximum):	Refills:
Physician Signature:		Date:
Indication:		
<input type="checkbox"/> Pulmonary Arterial Hypertension <input type="checkbox"/> Other (please describe): _____		
Documentation of Medical Criteria:		
<input type="checkbox"/> Patient is under the care of a Cardiologist or Pulmonologist. <input type="checkbox"/> Patient is enrolled in the Tracleer Access Program (Phone No: 866-228-3546; Fax No: 866-279-0669). <input type="checkbox"/> New York Heart Association Functional Classification: I II III IV <input type="checkbox"/> Diagnosis confirmed by right-heart catheterization.		
Other Pertinent History (relative or pertaining to this request):		