

**Physician's Prior Authorization Questionnaire  
Tracleer®**

**Patient:**

**ID#:**

**DOB:**

**Patient Address:**

Tracleer® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patient's diagnosis? *(Please identify the WHO Class.)* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. Have you registered with the Tracleer® Access Program?  Yes  No
3. If female, is the patient pregnant?  Yes  No
4. Has the patient been diagnosed with Pulmonary Artery Hypertension secondary to Left Ventricular Heart Failure?  Yes  No

***Tracleer® will be shipped to the patient from our Specialty Pharmacy***

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please **Print** Physician's Name & Specialty

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at [www.usableadmin.com/providers/PharmacyForms.aspx](http://www.usableadmin.com/providers/PharmacyForms.aspx)