

# STATEMENT OF MEDICAL NECESSITY (SMN)



PATIENT

Last name\*: \_\_\_\_\_ First name\*: \_\_\_\_\_ Birth date\*: \_\_\_\_\_ Gender\*:  Male  Female  
Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Home phone\*: (\_\_\_\_) \_\_\_\_\_ Work/cell phone: (\_\_\_\_) \_\_\_\_\_

INSURANCE\*

Insurance card attached (optional: see next page for details)

**Primary insurance:** \_\_\_\_\_  
Subscriber name: \_\_\_\_\_  
Name of insured: \_\_\_\_\_  
Policy #: \_\_\_\_\_  
Group #: \_\_\_\_\_  
Phone #: \_\_\_\_\_

**Secondary insurance:** \_\_\_\_\_  
Subscriber name: \_\_\_\_\_  
Name of insured: \_\_\_\_\_  
Policy #: \_\_\_\_\_  
Group #: \_\_\_\_\_  
Phone #: \_\_\_\_\_

PRESCRIPTION\*

OPSUMIT® (macitentan) new authorization  OPSUMIT re-authorization

Dose: \_\_\_\_\_  
Frequency: \_\_\_\_\_

DIAGNOSIS

Primary diagnosis\*: \_\_\_\_\_ ICD9 Code\*: \_\_\_\_\_

Is patient diagnosed with pulmonary arterial hypertension (PAH, WHO Group 1), defined as mean pulmonary arterial pressure  $\geq 25$  mmHg, pulmonary arterial wedge pressure  $\leq 15$  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

**Additional test results**

Functional class: \_\_\_\_\_  
Echocardiography: \_\_\_\_\_ Date: \_\_\_\_\_  
(See enclosed test results)

**Acute vasoreactivity testing (circle one)**

Patient responded      Patient did not respond

6-minute walk distance (6MWD): \_\_\_\_\_ Date: \_\_\_\_\_  
6-minute walk distance (6MWD): \_\_\_\_\_ Date: \_\_\_\_\_

Date of test: \_\_\_\_\_

PAST TREATMENTS

Ineffective, intolerant, or contraindicated treatments: \_\_\_\_\_  
Reason: \_\_\_\_\_  
Ineffective, intolerant, or contraindicated treatments: \_\_\_\_\_  
Reason: \_\_\_\_\_

PRESCRIBER\*

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Practice name: \_\_\_\_\_  
Specialty: \_\_\_\_\_  
Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_  
Prescriber Tax ID: \_\_\_\_\_ Prescriber NPI: \_\_\_\_\_ DEA #: \_\_\_\_\_

Sign and date here

Prescriber's signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*Required field(s).

## DIAGNOSIS/TREATMENT

- Be sure to include the ICD9 code
- Include any supporting documentation for diagnosis or past treatment. This could include test and lab results, a list of ineffective, intolerant, or contraindicated treatments, or Prescribing Information (typically for new therapies or new indications for existing therapies)
- Echocardiography results may be listed as:
  - PA pressure
  - TR jet
  - Right ventricular systolic pressure (RVSP)

## PRESCRIPTION

- Please ensure that all areas of the prescription portion are filled out clearly and completely, including the correct dosage

## PRESCRIBER

- This form cannot be processed without an original or stamped signature

## ATTACH TO COMPLETED SMN

- Attach a signed and dated letter
- Be sure to use the prior authorization (PA) form provided by the insurance company
- If the patient is insured, include the patient ID number from his or her insurance card