[Physician/Practice Letterhead]

[DATE]

[Payer Name] _____
RE: Adempas® (riociguat) coverage
[Payer Representative] _____
[Payer Address] _____
[City, State ZIP Code] _____
[Payer Fax Number] _____

[<Patient Name>] _____ [<Patient DOB>] _____
[<Policy Name>] _____ [<Group/Policy Number>] _____
[<Treatment Date and Claim Number>] _____
[<Amount of Claim>] _____
Attention: [<Payer Representative>], _____
[<Claims Department>] _____

Attention: [Medical/Pharmacy Director], [Department]

Dear [Medical/Pharmacy Director],

I am the treating [cardiologist/pulmonologist] for [Patient Name, Patient Member ID #], who has been under my care for [X months/years] for the management of [their condition], diagnosed according to ICD-10 criteria. I am reaching out to request a formulary exception for Adempas® (riociguat) [Dosage Strength, Route, Frequency].

This diagnosis was confirmed through appropriate diagnostic testing, including:

Right Heart Catheterization (RHC) performed on _____[DATE]_____ IF APPLICABLE - Vasoreactivity testing results: [POSITIVE/NEGATIVE]
[IF CTEPH - V/Q Scan or CT Angiography] performed on _____[DATE]_____ Current WHO Functional Class: [CLASS I/II/III/IV]
6-Minute Walk Distance (6MWD): [DISTANCE in meters] _____[DATE]_____

*Studies establishing effectiveness included predominantly patients with WHO Functional Class II–III.

[Provide a brief discussion of patient's relevant medical history, condition/symptoms, diagnostic test results, and therapy to date, including other treatments attempted and results.]

_____

_____

_____

MEDICAL NECESSITY FOR ADEMPAS

Adempas is medically necessary for [Patient Name] because:

- The patient has a documented diagnosis of [their condition] confirmed by appropriate diagnostic testing
- The patient has not achieved adequate clinical response with current formulary alternative therapies, and/or has contraindications to or intolerance of available alternatives

I have provided comprehensive clinical documentation in support of this request, including diagnostic test results, treatment history, and supporting clinical literature. Please do not hesitate to reach out to me if additional information is needed to facilitate approval of this formulary exception request. I respectfully request expedited review and approval of this request given the patient's clinical condition and need for this medication.

Sincerely,

[PRESCRIBER NAME]
[TITLE]
[NPI NUMBER]
[PHONE]
[FAX]