**Sample Format: Letter of Medical Necessity**

[Insert onto physician letterhead]

|  |  |
| --- | --- |
| [Medical Director][Insurance Company][Address][City, State ZIP] | **RE: Member Name** [Insert Member Name]**Member Number** [Insert Member Number]**Group Number** [Insert Group Number] |

**REQUEST:** Authorization for treatment with UPTRAVI® (selexipag)

**DIAGNOSIS:** [Insert Diagnosis] [Insert ICD]

**DOSE AND FREQUENCY:** [Insert Dose & Frequency]

**REQUEST TYPE:** ☐ Standard ☐ EXPEDITED

Dear [Insert Name of Medical Director]:

I am writing to support my request for an **authorization** for the above-mentioned patient to receive UPTRAVI® (selexipag) for the treatment of pulmonary arterial hypertension (PAH, WHO Group I), defined as mean pulmonary arterial pressure >20 mmHg, pulmonary arterial wedge pressure ≤15 mmHg, and pulmonary vascular resistance >2 Wood units.

UPTRAVI® is indicated for the treatment of pulmonary arterial hypertension (PAH, WHO Group I) to delay disease progression and reduce the risk of hospitalization for PAH. Effectiveness was established in a long-term study in PAH patients with WHO Functional Class II-III symptoms. Patients had idiopathic and heritable PAH (58%), PAH associated with connective tissue disease (29%), PAH associated with congenital heart disease with repaired shunts (10%).

My request is supported by the following:

**Summary of Patient’s Diagnosis**

[Insert patient’s diagnosis, date of diagnosis, lab results and date, current condition]

**Summary of Patient’s History**

[Insert summary of patient history per your medical judgment. You may want to include:

* Previous therapies/procedures and the patient’s response to those interventions
* Previous treatment of PAH including UPTRAVI®, if applicable, and patient’s response
* Brief description of the patient’s recent condition and test results (eg, right heart catheterization, acute vasoreactivity, echocardiography, functional class, oxygen use, or 6-minute walk distance)
* History of patient’s routine and non-routine visits, including ED if applicable
* Summary of your professional opinion of the patient’s likely prognosis without treatment with UPTRAVI®
* Summary of your credentials in treating PAH

Note: Exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient’s medical condition.]

**Rationale for Treatment**

[Insert summary statement for treatment rationale such as: Considering the patient’s history, condition, and the full Prescribing Information that supports uses of UPTRAVI®, I believe treatment with UPTRAVI® at this time is medically necessary and should be a covered therapy for my patient. You may consider including documents that provide additional clinical information to support the recommendation for UPTRAVI® for this patient, such as the full Prescribing Information, peer-reviewed journal articles, or clinical guidelines.]

[Given the urgent nature of this request,] please provide a timely authorization. Contact my office at [insert phone number] if I can provide you with any additional information.

Sincerely,

[Insert Physician Name and Participating Provider Number]

 **Please see full Important Safety Information for** [**UPTRAVI®**](https://uptravihcp.com/uptravi-important-safety-information/)**.**

Enclosures: [include full Prescribing Information and the additional support noted above].

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