

**ambrisentan, oral (LETAIRIS)**

**Diagnosis Considered for Coverage:**

- Pulmonary Arterial Hypertension (PAH), WHO Group 1

**Coverage Criteria:**

**For diagnosis listed above:**

- WHO group 1 classification, **and**
- Dose does not exceed 10 mg once daily.

**Coverage Duration:** one year

Effective Date: 11/29/2023