

# Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to:  **Commercial (Traditional)**     **Commercial Individual (Optimized)**

**Medicaid**

This request is:  **Urgent** (life threatening)     **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

## Tyvaso<sup>®</sup> (treprostinil)

### Member

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

ID #: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Requesting Provider: \_\_\_\_\_ Prov. Phone: \_\_\_\_\_ Prov. Fax: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Provider NPI: \_\_\_\_\_ Contact Name: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Product Information

New request     Continuation request

Drug product:  Tyvaso 1.75 mg/2.9 mL inhalation solution

Starter Kit

Refill Kit

**Start date** (or date of next dose): \_\_\_\_\_

**Date of last dose** (if applicable): \_\_\_\_\_

**Dose and frequency:** \_\_\_\_\_

Place of administration:  Self-administered

Home infusion

Facility: \_\_\_\_\_ NPI: \_\_\_\_\_ Fax: \_\_\_\_\_

Billing:  Preferred specialty vendor

Specialty Pharmacy

Pharmacy: \_\_\_\_\_ NPI: \_\_\_\_\_ Fax: \_\_\_\_\_

ICD code(s): \_\_\_\_\_

### Precertification Requirements

**Before this drug is covered, patient must meet the following criteria (please submit applicable medical records):**

1. Must have pulmonary arterial hypertension (PAH), World Health Organization (WHO) Group 1, AND all of the following:
  - a. WHO functional Class III symptoms prior to initiation of Tyvaso therapy
  - b. Documentation confirming diagnosis such as pre-treatment right heart catheterization with the following results:
    - i. MPAP  $\geq$  25mmHg
    - ii. PCWP  $\leq$  15 mmHg
    - iii. PVR > 3 Wood units

**Note:** Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

**Priority Health Precertification Documentation**

**A. What condition is this drug being requested for?**

- Pulmonary arterial hypertension
- Other – the patient’s condition is: \_\_\_\_\_

**B. What World Health Organization Group category does this patient’s clinical classification belong to?**

- Group 1
- Group 2
- Group 3
- Group 4
- Group 5

**C. What is the patient’s WHO functional class?**

- Class I
- Class II
- Class III
- Class IV

**Additional information**

WHO Group	Clinical classification	Etiology
1	Pulmonary arterial hypertension	<ul style="list-style-type: none"> <li>▪ Idiopathic, familial, congenital heart abnormalities</li> <li>▪ Connective tissue disorder</li> <li>▪ Portal hypertension</li> <li>▪ HIV</li> <li>▪ Anorexigen-induced PAH</li> </ul>
2	Pulmonary hypertension associated with left-sided heart disease	
3	Pulmonary hypertension associated with lung diseases or hypoxemia	
4	Chronic thromboembolic pulmonary hypertension	
5	Pulmonary hypertension with miscellaneous etiology	