



PRIOR AUTHORIZATION REQUEST

Tyvaso

PATIENT: Name _____
Address: _____
City, State, Zip _____
D.O.B. _____
Member ID: _____

Prescriber: Name _____
Address _____
City, State, Zip _____
Phone _____
Fax _____
NPI _____

Medication Requested: _____ **Qty Requested:** _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. What is the indication or diagnosis?
 - Pulmonary arterial hypertension (WHO Group 1 PAH) – **Please answer questions 2 – 11**
 - All other indications – Please specify _____
2. Yes No Does the patient have WHO Group 1 PAH?
3. Yes No Is the medication being prescribed by, or in consultation with, a cardiologist or a pulmonologist?
4. Yes No Is the patient currently receiving the requested medication?
5. Yes No Is documentation being provided to confirm that the patient has had a right heart catheterization?
6. Yes No Did the results of the right heart catheterization confirm the diagnosis of WHO Group 1 PAH?
7. Yes No Has the patient had a right heart catheterization?
8. Yes No Is the patient in Class III or IV of the WHO classification of functional status?
9. Yes No Is the patient in Class II of the WHO classification of functional status?
10. Yes No Has the patient tried or is the patient currently receiving one oral agent for PAH?
11. Yes No Has the patient tried one inhaled or parenteral prostacyclin product for PAH?

Please document the diagnoses, symptoms, and/or any other information important to this review:

**If you have any questions, call:
800-753-2851**



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SECTION B

Physician Signature

PHYSICIAN SIGNATURE

DATE

FAX COMPLETED FORM TO: 877-251-5896

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Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

**If you have any
questions, call:
800-753-2851**