maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Tyvaso DPI

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

1	Will the requested medication be used in combination with another oral or parenteral prostacyclin agent used for Pulmonary Hypertension? [NOTE: Examples of other medications include Orenitram (treprostinil extended-release tablets), Uptravi (selexipag tablets and intravenous infusion), epoprostenol intravenous infusion, and treprostinil subcutaneous or intravenous infusion.] [If yes, no further questions.]	Yes	No
2	Is the patient currently receiving the requested medication? [If no, skip to question 10.]	Yes	No
3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 10.]	Yes	No

If you have any questions, call:
1-888-258-8250

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4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [NOTE: If the patient does NOT have a previously approved authorization (PA) on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If yes, skip to question 6.]	Yes	No
5	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation. [NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.] [If yes, skip to question 10.] [If no, no further questions.]	Yes	No
6	Is this medication being prescribed by, or in consultation with, a cardiologist or a pulmonologist? [If no, no further questions.]	Yes	No
7	What is the indication or diagnosis? [] Pulmonary Arterial Hypertension (PAH) (World Health Organization (WHO) Group 1) (If checked, go to 8) [] Pulmonary Hypertension Associated with Interstitial Lung Disease (World Health Organization (WHO) Group 3). Note: This involves diagnoses such as, idiopathic interstitial pneumonia, combined pulmonary fibrosis and emphysema, World Health Organization (WHO) Group 3 connective disease, and chronic hypersensitivity pneumonitis. (If checked, go to 9) [] Other (If checked, no further questions)		
8	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation. [NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.] [No further questions.]	Yes	No
9	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation. [NOTE: Examples of a response include an increase or maintenance in the six-minute walk distance from baseline, improved exercise capacity, decrease in N-terminal pro-B-type natriuretic peptide levels, lessened clinical worsening, and a reduced rate of exacerbations of underlying lung disease.] [NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.] [No further questions.]	Yes	No
10	What is the indication or diagnosis? [] Pulmonary Arterial Hypertension (PAH) (World Health Organization (WHO) Group 1) (If		

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	checked, go to 11) [] Pulmonary Hypertension Associated with Interstitial Lung Disease (World Health Organization (WHO) Group 3). Note: This involves diagnoses such as, idiopathic interstitial pneumonia, combined pulmonary fibrosis and emphysema, World Health Organization (WHO) Group 3 connective disease, and chronic hypersensitivity pneumonitis. (If checked, go to 18) [] Other (If checked, no further questions)		
11	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
12	Does the patient have a documented diagnosis of World Health Organization (WHO) Group 1 pulmonary arterial hypertension (PAH) as evidenced by a right heart catheterization? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
13	According to the World Health Organization (WHO) Functional Classes of pulmonary hypertension, is the patient in Functional Class II, III or IV? [If no, no further questions.]	Yes	No
14	Does the patient have an intolerance, contraindication to, or trial and failure of TWO oral agents for pulmonary arterial hypertension (PAH)? [NOTE: Examples of oral agents for pulmonary arterial hypertension (PAH) include bosentan, ambrisentan, Opsumit (macitentan tablets), sildenafil, tadalafil, Adempas (riociguat tablets), Remodulin (treprostinil).] [If no, no further questions.]	Yes	No
15	Has the patient had a trial and failure to both inhaled prostacyclin products, Tyvaso (treprostinil inhalation solution) and Ventavis (iloprost inhalation solution) for at least 90 days? [If no, no further questions.]	Yes	No
16	Is the requested medication being prescribed by, or in consultation with, a cardiologist or a pulmonologist? [If no, no further questions.]	Yes	No

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

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SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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: 1-888-258-8250