Tyvaso

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: ______________________________ **Date**: ________________________________
Patient's ID: ________________________________ **Patient's Date of Birth:** ________________
Physician's Name: ____
Specialty: __________________________________ **NPI#:** __________________________________
Physician Office Telephone: __________________ **Physician Office Fax:** ___________________

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: _________________________ **Phone:** ______________________

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: _________________________ **Phone:** ______________________

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: __________________________*kg*

*Patient Height:*__________________________*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Tyvaso SGM - 06/2021.

Clinical Criteria Questions:

1. What is the diagnosis?
   ❑ Pulmonary arterial hypertension (PAH)
   ❑ Other ____

2. What is the ICD-10 code? ___________________

3. What is the World Health Organization (WHO) classification of pulmonary hypertension?
   ❑ **WHO Group 1** (Pulmonary hypertension) *Skip to #5*
   ❑ **WHO Group 2** (Pulmonary hypertension owing to left heart disease)
   ❑ **WHO Group 3**
   ❑ **WHO Group 4** (Chronic thromboembolic pulmonary hypertension)
   ❑ **WHO Group 5** (Pulmonary hypertension with unclear multifactorial mechanisms)

4. Does the patient have pulmonary hypertension associated with interstitial lung disease? ❑ Yes ❑ No

5. Is the request for continuation of therapy with Tyvaso? ❑ Yes ❑ No *If No, skip to #8*

6. Is the patient currently receiving the requested product through a paid pharmacy or medical benefit?
   ❑ Yes ❑ No ❑ Unknown *If No or Unknown, skip to #8*

7. Is the patient experiencing benefit from therapy as evidenced by disease stability or disease improvement?
   No further questions after answering
   ❑ Yes, disease stability
   ❑ Yes, disease improvement
   ❑ No, neither disease stability nor disease improvement

8. Has PH been confirmed by right heart catheterization? ❑ Yes ❑ No *If No, skip to #12*

9. What is the pretreatment mean pulmonary arterial pressure? ______________ mmHg

10. What is the pretreatment pulmonary capillary wedge pressure? ______________ mmHg

11. What is the pretreatment pulmonary vascular resistance? ______________ Wood units *No further questions*

12. Is the patient an infant less than one year of age? ❑ Yes ❑ No

13. Has Doppler echocardiogram been performed to diagnose PH? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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