



# 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 1-866-249-6155.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506**. 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.

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**Patient's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Patient's ID:** \_\_\_\_\_ **Patient's Date of Birth:** \_\_\_\_\_  
**Physician's Name:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Specialty:** \_\_\_\_\_ **Physician Office Fax:** \_\_\_\_\_  
**Physician Office Telephone:** \_\_\_\_\_  
**Request Initiated For:** \_\_\_\_\_

- What is the prescribed drug?  
 Tyvaso (treprostinil inhalation solution)  
 Tyvaso DPI (treprostinil inhalation powder)  
 Ventavis
- What is the patient's diagnosis?  
 Pulmonary hypertension (PH)  
 Other \_\_\_\_\_
- What is the ICD-10 code? \_\_\_\_\_

### Section A: Preferred Products

- Is the product being requested for the treatment of pulmonary arterial hypertension (PAH) WHO Group 1?  
 Yes  No *If No, skip to section B: All Requests*
- The preferred products for your patient's health plan are Tyvaso (treprostinil inhalation solution) and Ventavis. Can the patient's treatment be switched to a preferred product? ***If Yes, fax a new prescription to the pharmacy and no further questions.***  
 Yes: Please specify \_\_\_\_\_  
 No
- Is this request for continuation of therapy with the requested product?  Yes  No *If No, skip to #8*
- Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes.  Yes  No *If No, skip to section B: All Requests*
- Does the patient have a documented inadequate response to treatment with the preferred product Ventavis?  
***ACTION REQUIRED: If Yes, attach supporting chart note(s). If Yes, skip to section B: All Requests***  
 Yes  No
- Does the patient have a documented intolerable adverse event to the preferred product Ventavis?  
***ACTION REQUIRED: If Yes, attach supporting chart note(s). If Yes, skip to section B: All Requests***  
 Yes  No

**Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155**

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 ACSF SGM - 4/2023.

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10. Does the patient have a documented intolerable adverse event to the preferred product Tyvaso (treprostinil inhalation solution)? **ACTION REQUIRED: If Yes, attach supporting chart note(s).**  Yes  No
11. Was the documented intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information? **ACTION REQUIRED: If No, attach supporting chart note(s).**  
 Yes  No

Section B: All Requests

12. Is the requested medication prescribed by or in consultation with a pulmonologist or cardiologist?  Yes  No
13. Is the patient currently receiving treatment with the requested medication?  Yes  No *If No, skip to #16*
14. Is the patient currently receiving the requested medication through a paid pharmacy or medical benefit?  
 Yes  No  Unknown *If No or Unknown, skip to #16*
15. Is the patient experiencing benefit from therapy as evidenced by disease stability or disease improvement?  
*No further questions.*  
 Yes, disease stability  
 Yes, disease improvement  
 No, neither disease stability nor disease improvement
16. What is the World Health Organization (WHO) classification of pulmonary hypertension?  
 **WHO Group 1** (Pulmonary hypertension), *skip to #18*  
 **WHO Group 2** (Pulmonary hypertension owing to left heart disease)  
 **WHO Group 3** (PH due to lung diseases and/or hypoxia)  
 **WHO Group 4** (Chronic thromboembolic pulmonary hypertension)  
 **WHO Group 5** (Pulmonary hypertension with unclear multifactorial mechanisms)
17. Does the patient have pulmonary hypertension associated with interstitial lung disease?  Yes  No
18. Has PH been confirmed by right heart catheterization?  Yes  No *If No, skip to #22*
19. What is the pretreatment mean pulmonary arterial pressure (mPAP) at rest? \_\_\_\_\_ mmHg
20. What is the pretreatment pulmonary capillary wedge pressure (PCWP)? \_\_\_\_\_ mmHg
21. What is the pretreatment pulmonary vascular resistance (PVR)? \_\_\_\_\_ Wood units *No further questions.*
22. *If the patient is an infant less than one year of age*, has Doppler echocardiogram been performed to confirm the diagnosis?  Yes  No  N/A, patient is not an infant less than one year of age

***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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