Tyvaso
(Treprostinil)

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462 (800.88.CIGNA)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication Requested:
☐ Tyvaso
☐ **Other (please specify):** ICD10:

Dose and Quantity: Frequency of administration: Duration of therapy: J-Code (if injectable):

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

*****Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication (if injectable):
Facility Name: State: Tax ID#:

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use (please specify):
☐ Pulmonary arterial hypertension (WHO Group 1 PAH)
☐ Pulmonary hypertension associated with interstitial lung disease (WHO Group 3) (involves diagnosis such as idiopathic interstitial pneumonia, combined pulmonary fibrosis and emphysema, WHO Group 3 connective disease, and chronic hypersensitivity pneumonitis)
☐ Other (please specify):

Clinical Information:

Is the medication being prescribed by or in consultation with a cardiologist or a pulmonologist? ☐ Yes ☐ No

For PAH WHO Group 1

Is the patient currently receiving the requested inhaled prostacyclin? ☐ Yes ☐ No

(if not currently receiving) Is documentation being provided to confirm that the patient has had a right heart catheterization? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes and catheterization laboratory reports. For a patient case in which the documentation requirement of the right heart catheterization upon prior authorization coverage review for a different medication indicated for WHO Group 1 PAH has been previously provided, the documentation requirement in this Pulmonary Arterial Hypertension - Inhaled Prostacyclin Products Prior Authorization Policy is considered to be met.
☐ Yes ☐ No

(if yes) Did the results of the right heart catheterization confirm the diagnosis of WHO Group 1 PAH? ☐ Yes ☐ No

(if not currently receiving) Is the patient in Class III or IV of the WHO classification of functional status? ☐ Yes ☐ No

(if no) Is the patient in Class II of the WHO classification of functional status? ☐ Yes ☐ No

(if not currently receiving) Has the patient tried or is the patient currently receiving one oral agent for PAH? Note: Examples of oral agents for PAH include bosentan, ambrisentan, Opsumit (macitentan tablets), sildenafil, tadalafil, Adempas (riociguat tablets). ☐ Yes ☐ No

(if no) Has the patient tried one inhaled or parenteral prostacyclin product for PAH? Note: Examples of inhaled and parenteral prostacyclin products for PAH include Tyvaso (treprostinil inhalation solution), Tyvaso DPI (treprostinil oral inhalation powder), Yutrepia (treprostinil oral inhalation powder), Ventavis (iloprost inhalation solution), treprostinil injection, and epoprostenol injection. ☐ Yes ☐ No

(if currently receiving) Has the patient had a right heart catheterization? Note: This refers to prior to starting therapy with a medication for WHO Group 1 PAH. ☐ Yes ☐ No

(if yes) Did the results of the right heart catheterization confirm the diagnosis of WHO Group 1 PAH? ☐ Yes ☐ No

For PAH WHO Group 3

Is the patient currently receiving the requested medication for pulmonary hypertension associated with interstitial lung disease? ☐ Yes ☐ No

(if not currently receiving) Is documentation being provided to confirm that the patient has had a right heart catheterization? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes and catheterization laboratory reports.
Notes: Please Note: A "yes" answer must be reviewed by a member of the UMP/nurse team ☐ Yes ☐ No

(if yes) Did the results of the right heart catheterization confirm the diagnosis of WHO Group 3 pulmonary hypertension associated with interstitial lung disease? ☐ Yes ☐ No

(if not currently receiving) Does the patient have connective tissue disease? ☐ Yes ☐ No

(if yes) Does the patient have a baseline forced vital capacity lower than 70%? ☐ Yes ☐ No

(if not currently receiving) Does the patient have evidence of diffuse parenchymal lung disease on computed tomography of the chest? ☐ Yes ☐ No

(if currently receiving) Has the patient had a right heart catheterization? Note: This refers to prior to starting therapy with a medication for WHO Group 3 PAH. ☐ Yes ☐ No

(if yes) Did the results of the right heart catheterization confirm the diagnosis of WHO Group 3 pulmonary hypertension associated with interstitial lung disease? ☐ Yes ☐ No

(if currently receiving) Has the patient had a response to therapy according to the prescriber? 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. ☐ Yes ☐ No

Additional pertinent information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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