Tyvaso DPI (treprostinil)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED:			
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
□ Pulmonary arterial hypertension (PAH) □ Pulmonary hypertension associated with interstitial lung disease(PH-ILD) □ Other diagnosis: _____ICD-10_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Is the prescribing physician a specialist in one of the following fields: pulmonology, cardiology, nephrology, or rheumatology? □ Yes □ No

<u>For diagnosis of Pulmonary Arterial Hypertension (PAH), please answer the following</u>:

Does the patient have a diagnosis of pulmonary arterial hypertension (PAH) WHO Group 1? □ Yes □ No Please provide documentation.

Select if the patient has the following causes for pulmonary arterial hypertension (PAH):

- **□ Idiopathic/primary PAH**
- **□ Drugs and toxins induced**
- **□ Connective tissue disease (e.g., Lupus/SLE, RA, scleroderma, systemic sclerosis, CREST syndrome, polymyositis, polyarteritis nodosa, mixed connective tissue disease)**
- **□ HIV infection**
- **□ Portal hypertension**
- **□ Congenital heart disease**
- **□ Schistosomiasis**
- **□ Chronic hemolytic anemia**

Select if the patient's cardiac catheterization report meets the following:*

- **□ MPAP greater than 25 mmHg + PCWP less than 19 mmHg / LVEDP not reported**
- **□ MPAP greater than 25 mmHg + LVEDP less than 19 mmHg / PCWP not reported**
- **□ MPAP greater than 25 mmHg + PCWP less than 19 mmHg + LVEDP less than 19 mmHg**

Please provide a copy of the report.

Has patient had an inadequate response or intolerance to a PDE5 inhibitor such as Revatio(sildenafil and/or Adcirca(tadalafil)? □ Yes □ No Please provide documentation.

Does patient have contraindications to PDE5 inhibitors Revatio(sildenafil and/or Adcirca(tadalafil)? □ Yes □ No Please provide documentation.

Has patient had an inadequate response or intolerance to Adempas (riociguat) ? □ Yes □ No Please provide documentation.

Does patient have contraindications to Adempas (riocguat)? □ Yes □ No Please provide documentation.

Has patient had an inadequate response or intolerance to an endothelin receptor antagonist [e.g., Letairis (ambrisentan), Opsumit (macitentan), or Tracleer (bosentan)]? □ Yes □ No Please provide documentation.

Does patient have contraindications to an endothelin receptor antagonist [e.g., Letairis (ambrisentan), Opsumit (macitentan), or Tracleer (bosentan)]? □ Yes □ No Please provide documentation.

Will Orenitram(treprostinil) be taken in combination with a prostanoid/prostacyclin analogue (e.g., epoprostenol, iloprost, treprostinil, and/or selexipag)? □ Yes □ No Please provide documentation.

For diagnosis of pulmonary hypertension associated with interstitial lung disease, please answer the following:

Does patient have WHO Group 3 pulmonary hypertension, defined as an elevation in pulmonary arterial pressure *and* pulmonary vascular resistance? □ Yes □ No Please provide documentation.

Does patient have confirmed diagnosis based on computed tomography imaging and pulmonary function tests performed within the past six months of WHO Group 3PH associated with one of the following? □ Yes □ No
Please provide documentation.
□ Idiopathic interstitial pneumonia (IIP)
□ Idiopathic pulmonary fibrosis (IPF)
□ Idiopathic nonspecific interstitial pneumonia
□ Respiratory bronchiolitis-associated interstitial lung disease (RB-ILD)
□ Desquamative interstitial pneumonia (DIP)
□ Cryptogenic organizing pneumonia (COP)
□ Acute interstitial pneumonitis (AIP)
□ Idiopathic lymphoid interstitial pneumonia
□ Idiopathic pleuroparenchymal

Has patient had a right heart catheterization (RHC) within 1 year prior to starting Tyvaso DPI (treprostinil) with the following documented parameters? □ Yes □ No Please provide documentation.

□ Pulmonary vascular resistance (PVR) >3 Wood Units (WU)

□ A pulmonary capillary wedge pressure (PCWP) of ≤ 15 mmHg

□ A mean pulmonary arterial pressure (mPAP) of > 25 mmHg

Does patient have a baseline 6MWD (six minute walking distance) ≥100 m before starting Tyvaso DPI? □ Yes □ No
Please provide documentation.

Does patient have connective tissue disease (CTD)? □ Yes □ No
If patient has connective tissue disease (CTD, does patient have a forced vital capacity (FVC) of <70%? □ Yes □ No
Please provide documentation.

Does patient have evidence of clinically significant left-sided heart disease as defined by PCWP >15 mmHg, AND/OR Left ventricular ejection fraction <40%? □ Yes □ No Please provide documentation.

Is the patient receiving greater than 10 L/min of oxygen supplementation by any mode of delivery at rest? □ Yes □ No Please provide documentation.

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or 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 or Electronic I.D. Verification: _____ Date: _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811