Please complete ALL information below and fax your request to 1-888-671-5285

Tyvaso® & Ventavis® Coverage Determination Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:	Office Contact:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type(s) of Coverage Determination Requested:

❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

❑ **Quantity Limit**- Request is for an exception to the plan's quantity limit.

Quantity per DAY requested? _________

Select the diagnosis below:

❑ Pulmonary arterial hypertension (PAH) WHO Group I with New York Heart Association (NYHA) Functional Class II to IV

❑ Other diagnosis: ____ ICD-10 Code(s): ____________________________________

Prescriber's Specialty:

Select if Tyvaso or Ventavis is prescribed by one of the following specialists:

❑ Cardiologist ❑ Pulmonologist

Clinical Information:

Has the patient's diagnosis been confirmation by catheterization (right-heart or Swan-Ganz) or echocardiography? ❑ **Yes** ❑ **No**

Is there documentation the patient has mean pulmonary artery pressure greater than or equal to 25 mm Hg at rest OR mean pulmonary artery pressure greater than 30 mm Hg with exertion? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation the patient has had stabilization or improvement as evaluated by a cardiologist or pulmonologist? ❑ **Yes** ❑ **No**

Quantity Limit Requests:

Is there a high risk of significant adverse clinical outcome with medication change or dosage change? ❑ **Yes** ❑ **No**

Is the requested quantity and dose within FDA approved maximum dosing limits or supported by peer-reviewed medical literature, accepted standards of medical practice and/or medical compendia? ❑ **Yes** ❑ **No**

If **yes,** please specify:____

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

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Please note: This request may be denied unless all required information is received.

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