Tyvaso

CareFirst 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*

What is the ICD-10 code? _____

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

Criteria Questions:

1. What is the diagnosis?

❒ Pulmonary hypertension (PH), *Continue to 2*

❒ Other, please specify. _____, *Continue to 2*

2. Is the requested drug prescribed by or in consultation with a pulmonologist or cardiologist?
❒ Yes, *Continue to 3*
❒ No, *Continue to 3*

3. Is the patient currently receiving treatment with the requested drug?
❒ Yes, *Continue to 4*
❒ No, *Continue to 6*

4. Is the patient currently receiving the requested drug through a paid pharmacy or medical benefit?

❒ Yes, *Continue to 5*

❒ No, *Continue to 6*

❒ Unknown, *Continue to 6*

5. Is the patient experiencing benefit from therapy with the requested drug as evidenced by disease stability or disease improvement?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

6. What is the World Health Organization (WHO) classification of pulmonary hypertension?

❒ WHO Group 1 (Pulmonary arterial hypertension), *Continue to 8*

❒ WHO Group 2 (Pulmonary hypertension associated with left heart disease), *No further questions*

❒ WHO Group 3 (Pulmonary hypertension associated with lung diseases and/or hypoxia), *Continue to 7*

❒ WHO Group 4 (Pulmonary hypertension associated with pulmonary artery obstructions), *No further questions*

❒ WHO Group 5 (Pulmonary hypertension with unclear and/or multifactorial mechanisms), *No further questions*

7. Does the patient have pulmonary hypertension associated with interstitial lung disease?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Has pulmonary hypertension been confirmed by pretreatment right heart catheterization?
❒ Yes, *Continue to 9*
❒ No, *Continue to 15*

9. What is the pretreatment mean pulmonary arterial pressure (mPAP)?

❒ Greater than 20 mmHg, *Continue to 10*

❒ Less than or equal to 20 mmHg, *Continue to 10*

10. What is the pretreatment pulmonary capillary wedge pressure (PCWP)?

❒ Less than or equal to 15 mmHg, *Continue to 11*

❒ Greater than 15 mmHg, *Continue to 11*

11. Is the patient less than 18 years of age?
❒ Yes, *Continue to 13*
❒ No, *Continue to 12*

12. What is the pretreatment pulmonary vascular resistance (PVR)?

❒ Greater than 2 Wood units, *No further questions*

❒ Less than or equal to 2 Wood units, *No further questions*

13. What is the pretreatment pulmonary vascular resistance (PVR)?

❒ Greater than 2 Wood units, *No further questions*

❒ Less than or equal to 2 Wood units, *Continue to 14*

14. What is the pretreatment pulmonary vascular resistance index (PVRI)? (Note: m2 represents unit of body surface area, meters squared.)

❒ Greater than 3 Wood units x m2, *No further questions*

❒ Less than or equal to 3 Wood units x m2, *No further questions*

15. Is the patient an infant less than one year of age?
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

16. Has Doppler echocardiogram been performed to confirm the diagnosis?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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)**

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

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com