



Federal Employee Program. **TYVASO** PRIOR APPROVAL REQUEST

Send completed form to:  
Service Benefit Plan  
Prior Approval  
P.O. Box 52080 MC 139  
Phoenix, AZ 85072-2080  
Attn. Clinical Services  
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)				Provider Information (required)		
Date:				Provider Name:		
Patient Name:				Specialty:		NPI:
Date of Birth:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Office Phone:		Office Fax:
Street Address:				Office Street Address:		
City:		State:	Zip:	City:		State: Zip:
Patient ID: <b>R</b> <input type="text"/>				Physician Signature:		
<b>PHYSICIAN COMPLETES</b>						

**Tyvaso (treprostinil)**

**\*\*Check [www.fepblue.org/formulary](http://www.fepblue.org/formulary) to confirm which medication is part of the patient's benefit**

**NOTE: Form must be completed in its **entirety** for processing**

Is this request for brand or generic? ☐ Brand ☐ Generic

1. What is the patient's diagnosis?

- ☐ Pulmonary arterial hypertension (PAH) (WHO Group 1)
- ☐ Pulmonary hypertension associated with interstitial lung disease (PH-ILD) (WHO Group 3)
- ☐ Pulmonary hypertension
- a. What is the cause of the pulmonary hypertension? ***Please select answer below:***
- |   |  |
|---|--|
| <input type="checkbox"/> Congenital heart disease (WHO Group 1)           | <input type="checkbox"/> Pulmonary veno-occlusive disease (PVOD) (WHO Group 1)                 |
| <input type="checkbox"/> Connective tissue disease (WHO Group 1)          | <input type="checkbox"/> Pulmonary capillary hemangiomatosis (PCH) (WHO Group 1)               |
| <input type="checkbox"/> Drugs or toxins induced (WHO Group 1)            | <input type="checkbox"/> Persistent pulmonary hypertension of the newborn (PPHN) (WHO Group 1) |
| <input type="checkbox"/> Heritable PAH (WHO Group 1)                      | <input type="checkbox"/> Left heart disease (WHO Group 2)                                      |
| <input type="checkbox"/> HIV infection (WHO Group 1)                      | <input type="checkbox"/> Lung disease or hypoxemia (WHO Group 3)                               |
| <input type="checkbox"/> Idiopathic/Unknown cause (WHO Group 1)           | <input type="checkbox"/> Chronic thrombotic or embolic disease (CTEPH) (WHO Group 4)           |
| <input type="checkbox"/> Portal hypertension (WHO Group 1)                | <input type="checkbox"/> Unclear multifactorial mechanisms (WHO Group 5)                       |
| <input type="checkbox"/> Schistosomiasis (WHO Group 1)                    |  |
| <input type="checkbox"/> Other cause ( <i>please specify</i> ): _____     |  |
| <input type="checkbox"/> Other diagnosis ( <i>please specify</i> ): _____ |  |

2. **Lung Disease or Hypoxemia (WHO Group 3):** Does the patient have pulmonary hypertension associated with interstitial lung disease (PH-ILD)? ☐ Yes ☐ No

3. Will Tyvaso be used in combination with antiplatelets or anticoagulants? ☐ Yes\* ☐ No

**\*If YES**, does the prescriber agree to monitor for signs and symptoms of bleeding? ☐ Yes ☐ No

4. Has the patient been on this medication continuously for the last **6 months, excluding samples**? ***Please select answer below:***

☐ **NO** – this is **INITIATION** of therapy, please answer the following questions:

a. Has this medication been prescribed by or recommended by either a cardiologist or pulmonologist? ☐ Yes ☐ No

b. **Pulmonary Arterial Hypertension (PAH: WHO Group 1):** What level of activity causes the patient to experience shortness of breath or fatigue? ***Please select answer below:***

- ☐ No symptoms and no limitations in ordinary activity (Class I)
- ☐ Mild symptoms and slight limitation during ordinary activity (Class II)
- ☐ Marked limitation in activity due to symptoms, even during less than ordinary activity (Class III)
- ☐ Experiences shortness of breath and fatigue while at rest (Class IV)

☐ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

a. Have the patient's symptoms improved or stabilized? ☐ Yes ☐ No



**BlueCross  
BlueShield**

Federal Employee Program.

**TYVASO**

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

<p><b>Electronically Online</b> (ePA) Results in 2-3 minutes <b>FASTEST AND EASIEST</b></p>	<p>Now you can get responses to drug Prior Authorization requests <b>securely</b> online. <b>Online</b> submissions may receive <b>instant</b> responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to <b>Caremark.com/ePA.</b></p>
<p><b>Phone</b> (4-5 minutes for response)</p>	<p>The FEP Clinical Call Center can be reached at <b>(877)-727-3784</b> between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.</p>
<p><b>Fax</b> (3-5 days for response)</p>	<p>Fax the attached form to <b>(877)-378-4727</b>. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. <b><u>Please only fax the completed form once as duplicate submissions may delay processing times.</u></b></p>

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easier...  
better...**

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