

AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Pulmonary Hypertension associated with Interstitial Lung Disease (PH-ILD) Drugs – WHO Group 3)

Drug Requested: select one drug below

<input type="checkbox"/> Tyvaso[®] (treprostinil)	<input type="checkbox"/> Yutrepia[™] (treprostinil)
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MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight (if applicable): _____ Date weight obtained: _____

Recommended Dosage and Quantity Limits:

Tyvaso

- **Initial:** 18 mcg (3 inhalations) 4 times per day administered every 4 hours while patient is awake
- **Maintenance:** If tolerated, increase each dose by 3 inhalations at ~1- to 2-week intervals; studies establishing effectiveness used a target dose of 72 mcg (12 inhalations) 4 times per day

Yutrepia

- **Initial:** 26.5 mcg (in 2 breaths) inhaled 3 to 5 times per day.
- **Maintenance:** If tolerated, increase each inhaled dose (in 2 breaths) by an additional 26.5 mcg every week; target dose: 79.5 to 106 mcg inhaled 4 times daily.

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Drug Name	Drug strength/formulation	Quantity (units)	Days of Supply
Tyvaso®	1.74 mg/2.9 mL ampule	28	28
Yutrepia™	26.5 mcg, 53 mcg, 79.5 mcg & 106 mcg inhalation capsules	112	28

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 6 months

- ☐ Member is 18 years of age or older
- ☐ Prescribing physician is a clinician with expertise in treating patients with pulmonary hypertension who have a diagnosis of interstitial lung disease (PH-ILD)
- ☐ The diagnosis of WHO Group 3 (PH-ILD) has been confirmed by an expert center meeting the following hemodynamic definitions obtained from a right heart catheterization (**Medical chart notes and results from the right heart catheterization, laboratory documentation, imaging results, pulmonary function tests, arterial blood gases, etc. are required to be submitted with this request**):
 - ☐ A mean arterial pressure (mPAP) measured ≥ 20 mmHg at rest
 - ☐ A pulmonary artery wedge pressure (PAWP) measured ≤ 15 mmHg
 - ☐ A pulmonary vascular resistance (PVR) measured ≥ 3 Woods Units
- ☐ A high-resolution computed tomography has been obtained confirming observation of parenchymal lung disease characteristic of WHO Group 3 (**imaging, medical chart, and/or procedural results are required to be submitted with this request**)
- ☐ For initiating therapy: The member's forced vital capacity (FVC) is $< 70\%$ of the predicted value (**Please provide supporting documentation including a pulmonary function test (PFT) report and/or chart notes**)
- ☐ A baseline assessment of exercise capacity, current clinical/disease status, and/or walking distance ability has been provided (**Please provide supporting documentation including progress notes and/or chart notes detailing applicable clinical information such as walking distance, number of recent exacerbations of underlying lung disease, levels of N-terminal pro-B-type natriuretic peptide, etc.**)

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Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ☐ Provider has submitted clinical documentation of stable disease, improvement in lung function, or response to therapy (**Medical chart notes, laboratory documentation, imaging results, pulmonary function tests, and any applicable clinical information is required to be submitted with this request to confirm improvement in exercise capacity/walking distance, lessened clinical worsening, reduced exacerbations of underlying lung disease, improvement in laboratory values**)
- ☐ Provider confirms that the member is not experiencing any toxicity from drug treatment (i.e. moderate-severe liver toxicity, low systemic blood pressure, increased bleeding)

Medication being provided by Specialty Pharmacy – Proprium Rx

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

*****Use of samples to initiate therapy does not meet step edit/preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****