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.**

Drug Requested: Tyvaso® (inhaled treprostinil) for PH-ILD (WHO Group 3)

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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

Recommended Dosage and Quantity Limits:

- **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

Drug Name	Drug strength/formulation	Quantity (units)	Days of Supply
Tyvaso®	1.74 mg/2.9 mL ampule	28	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 Approval: 6 months

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- ❑ 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 ≥ 20mmHg at rest
  - ❑ A pulmonary artery wedge pressure (PAWP) measured ≤ 15mmHg
  - ❑ 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.)**

Reauthorization Approval: 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 - PropriumRx

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.****