

Referral Form for TYVASO



Tyvaso is available only through select Specialty Pharmacy Services (SPS) providers.
Follow these 6 steps to complete each section of the following referral form.

GET STARTED CHECKLIST

- 1 Fill out the Patient and Insurance Information. Let your patient know that an SPS provider will be calling and it is important to answer or return the call.
- 2 Complete and sign the Prescriber Information, Prescription, Medical Information and Statement of Medical Necessity.
- 3 Complete and sign the Treatment History and Calcium Channel Blocker Statement (Calcium Channel Blocker Statement not required for PH-ILD).
- 4 Complete the Optional Side Effect Management page.
- 5 Attach the clinical documents outlined on the **fax cover sheet**, including right heart catheterization test results, history and physical, and echocardiogram results.
- 6 Use the **fax cover sheet** included in this PDF to fax the referral form and signed supporting documents to your SPS provider. (Insurance plans vary and may impact the approval process.)

STEP 1 PATIENT INFORMATION

Name - First	Middle	Last
Date of Birth	Gender	Last 4 digits of SSN
Home Address		
City	State	Zip
Shipping Address (if different from home address)		
City	State	Zip
Telephone	Alternate Telephone	Best Time to Call
E-mail Address		Morning Afternoon Evening
Caregiver/Family Member	Telephone	Alternate Telephone

STEP 1 INSURANCE INFORMATION

Primary Prescription Insurance		
Subscriber ID#	Group #	Telephone
Primary Medical Insurance		
		Policy Holder/Relationship
Subscriber ID#	Group #	Telephone
Secondary Medical Insurance		
		Policy Holder/Relationship
Subscriber ID#	Group #	Telephone

Please include copies of the front and back of the patient's insurance card(s).

Patient Name: _____ Date of Birth: _____

STEP 2 PRESCRIBER INFORMATION

Prescriber Name - First	Last	NPI#	State License#	
Facility Name		Office Contact Name		
Address		City	State	Zip
Telephone	Fax	Email Address		
Preferred Method of Communication Phone Email Mail Fax				

STEP 2 MEDICAL INFORMATION / PATIENT EVALUATION / SUPPORTING DOCUMENTATION

Patient Product Therapy Status for the requested drug:			Current Specialty Pharmacy:		Patient Status:		WHO Group:
Naïve/New	Restart	Transition	CVS Specialty		Outpatient	Inpatient	_____
NYHA Functional Class (PAH Only):			Weight: _____ kg lb	Diabetic:	Allergies:		
I	II	III	IV	Height: _____ft____in	Yes No	Drug Allergies	Non-Drug Allergies
					No Known Allergies		

Current Signed and Dated Documents Required For Treprostinil Therapy Initiation: Right Heart Catheterization Echocardiogram
 Treatment History (included on the next page) Transition Statement (if applicable) Calcium Channel Blocker Statement (not required for PH-ILD patients)
 History and Physical Including: Onset of Symptoms, PAH or PH associated with ILD Clinical Signs and Symptoms, Need for Specific Drug Therapy, Course of Illness

Diagnosis - The following ICD-10 codes do not suggest approval, coverage or reimbursement for specific uses or indications.

PAH - Use this section for PAH	PH-ILD - Use this section for PH-ILD
ICD-10 I27.0 Primary pulmonary hypertension: Idiopathic PAH Heritable PAH ICD-10 I27.20 Pulmonary hypertension, unspecified ICD-10 I27.21 Secondary pulmonary arterial hypertension: Connective tissue disease Drugs/Toxins induced Portal Hypertension HIV Congenital Heart Diseases Other: _____ Other ICD-10: _____	Please include one PH specific diagnosis code AND one ILD specific diagnosis code. PH Diagnosis Codes: ICD-10 I27.23 Pulmonary hypertension due to lung diseases and hypoxia Other ICD-10: _____ ILD Diagnosis Codes: IIP: ICD-10 J84.10 Pulmonary fibrosis, unspecified ICD-10 J84.111 Idiopathic interstitial pneumonia, NOS ICD-10 J84.112 Idiopathic pulmonary fibrosis
	CTD-related ILD: ICD-10 M34.81 Systemic sclerosis with lung involvement Environmental/Occupational Lung Disease: ICD-10 J61 Pneumoconiosis due to asbestos and other mineral fibers ICD-10 J67.9 Hypersensitivity pneumonitis due to unspecified dust Other Causes: ICD-10 J17 Pneumonia in disease classified elsewhere Other ICD-10: _____

Please visit www.utassist.com/codes for additional ICD-10 codes related to PAH, PH, and ILD

PAH - Prescriber use this section for PAH Prescription	PH-ILD - Prescriber use this section for PH-ILD Prescription
TYVASO (treprostinil) 1.74mg/2.9ml ampule (0.6mg/ml) Inhalation Solution Target dose: 9 breaths (54 mcg) to 12 breaths (72mcg), 4 times a day - Start with 3 breaths (18 mcg) 4 times a day (if 3 breaths are not tolerated, use 1 to 2 breaths). Increase by additional 3 breaths at 1- to 2-week intervals, if tolerated, until the target dose of 9 breaths (54 mcg) to 12 breaths (72 mcg), 4 times a day. Quantity: TYVASO Inhalation System Starter Kit (28-day supply) TYVASO Inhalation System Refill Kit (28-day supply) X _____ refills Prescriber may specify any alternative or additional dosing and titration instructions here: _____ <i>Specialty Pharmacy to contact prescribing practitioner for adjustments to the written orders specified above.</i>	TYVASO (treprostinil) 1.74mg/2.9ml ampule (0.6mg/ml) Inhalation Solution Target dose: 9 breaths (54 mcg) to 12 breaths (72 mcg), 4 times a day - Start with 3 breaths (18 mcg) 4 times a day (if 3 breaths are not tolerated, use 1 to 2 breaths). Increase by additional 1 breath per week, if tolerated, until the target dose of 9 breaths (54 mcg) to 12 breaths (72 mcg), 4 times a day. Quantity: TYVASO Inhalation System Starter Kit (28-day supply) TYVASO Inhalation System Refill Kit (28-day supply) X _____ refills Prescriber may specify any alternative or additional dosing and titration instructions here: _____ <i>Specialty Pharmacy to contact prescribing practitioner for adjustments to the written orders specified above.</i>

NURSING ORDERS RN visit to provide assessment and education on administration, dosing, and titration. **Location:** Home Outpatient Clinic Hospital

The Prescriber is to comply with their state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance of state specific requirements could result in outreach to the Prescriber.

Nurse Visits **Specialty Pharmacy home healthcare RN visit** OR **Prescriber directed Specialty Pharmacy home healthcare RN visit(s) as detailed below:**

CHECK ONE to provide education on self-administration of Tyvaso including dose, titration, and side effect management. _____

STEP 2 PRESCRIBER SIGNATURE: PRESCRIPTION AND STATEMENT OF MEDICAL NECESSITY

I certify that the pulmonary arterial hypertension therapy ordered above is medically necessary and that I am personally supervising the care of this patient.
PHYSICIAN'S SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS.

Physician's signature: _____ Dispense as written _____ Substitution Allowed _____ Date: _____

State Specific Dispense as Written (DAW) Selection Verbiage : _____

(Physician attests this is his/her legal signature. NO STAMPS.) PRESCRIPTIONS MUST BE FAXED.

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Patient Name: _____ Date of Birth: _____

STEP 3 TREATMENT HISTORY AND TRANSITION STATEMENT

Please indicate Treatment History

Medication	Current	Discontinued
PDE-5 I (specify drug(s)):		
Epoprostenol		
Flolan® (epoprostenol sodium) for Injection		
Letairis® (ambrisentan) Tablets		
Remodulin® (treprostinil) Injection		
Tracleer® (bosentan) Tablets		
Tyvaso® (treprostinil) Inhalation Solution		
Veletri® (epoprostenol) for Injection		
Ventavis® (iloprost) Inhalation Solution		
Adempas® (riociguat) Tablets		
Opsumit® (macitentan) Tablets		
Orenitram® (treprostinil) Extended-Release		
Uptravi® (selexipag) Tablets		
Ofev® (nintedanib) Capsules		
Esbriet® (pirfenidone) Tablets		
Other:		

Transition Statement

It is necessary for this patient (if applicable) to transition

FROM _____ **TO** _____

Please provide justification for this transition.

STEP 3 CALCIUM CHANNEL BLOCKER STATEMENT (Not required for PH-ILD patients)

Please indicate below if the Patient named above was trialed on a Calcium Channel Blocker prior to the initiation of therapy and indicate the results.

A Calcium Channel Blocker was not trialed because:

- Patient has depressed cardiac output
- Patient has systemic hypotension
- Patient has known hypersensitivity
- Other: _____
- Patient is hemodynamically unstable or has a history of postural hypotension
- Patient did not meet ACCP Guidelines for Vasodilator Response
- Patient has documented bradycardia or second- or third-degree heart block

OR

The following Calcium Channel Blocker was trialed:

With the following response(s):

- Patient hypersensitive or allergic _____
- Adverse event _____
- Disease continued to progress or patient remained symptomatic _____
- Other: _____
- Pulmonary arterial pressure continued to rise
- Patient became hemodynamically unstable

STEP 3 PRESCRIBER SIGNATURE

**SIGN
HERE**

Prescriber Name: _____ Prescriber Signature: _____ Date: _____

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Fax the completed referral form and documentation to your specialty pharmacy.

STEP 4 FAX COVER SHEET

Date: _____

To: CVS Specialty
Fax: 1-877-943-1000
Phone: 1-877-242-2738

From: (Name of agent of prescriber who transmitted the facsimile/Prescription)

Facility Name: _____

Fax: _____

Included in this fax:

Completed Tyvaso Therapy Referral Form including

- Step 1 - Patient Information/Insurance Information (Including front and back copies of insurance card)
Step 2 - Prescriber/Prescription Information/Medical Information/Patient Evaluation
Step 3 - Treatment History/Transition Statement and Calcium Channel Blocker Statement (Calcium Channel Blocker Statement not required for PH-ILD)
Step 4 - Optional Side Effect Management

Included signed and dated documents

- Right Heart Catheterization Results
History and Physical (including Onset of Symptoms, PAH or PH associated with ILD Clinical Signs and Symptoms, Course of Illness)
Need for Specific Drug Therapy and 6-minute walk test results (6-minute walk test not required for PH-ILD)
Echocardiogram Results

Number of Pages: _____

Additional Comments:

