

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.
- 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 preferred 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 TYVASO PRESCRIPTION INFORMATION

TYVASO (treprostinil)
1.74mg/2.9ml ampule (0.6mg/ml) Inhalation Solution
Target dose: 9 breaths (54 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 3 breaths at 1- to 2-week intervals, if tolerated, until the target dose of 9 breaths (54 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:

Specialty Pharmacy to contact prescribing practitioner for adjustments to the written orders specified above.

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 - Please select an option:

Specialty Pharmacy home healthcare RN visit to provide education on self-administration of Tyvaso including dose, titration, and side effect management.
OR
Prescriber directed Specialty Pharmacy home healthcare RN visit(s) as detailed below:

STEP 2 MEDICAL INFORMATION / PATIENT EVALUATION / SUPPORTING DOCUMENTATION

Patient UT PAH Product Therapy Status for the requested drug:
 Naïve/New Restart Transition
Current Specialty Pharmacy: Accredo CVS Caremark **Patient Status:** Outpatient Inpatient **WHO Group:** _____
NYHA Functional Class: I II III IV **Weight:** _____ kg lb **Height:** _____ ft _____ in
Diabetic: Yes No
Allergies: Drug Allergies Non-Drug Allergies No Known Allergies
Diagnosis - The following ICD-10 codes do not suggest approval, coverage or reimbursement for specific uses or indications:

ICD-10 I27.0 Primary pulmonary hypertension:	ICD-10 I27.2 Other chronic pulmonary heart diseases: pulmonary arterial hypertension, secondary:
Idiopathic PAH	Connective tissue disease Portal Hypertension
Heritable PAH	Congenital Heart Disease HIV
	Drugs/Toxins induced Other _____

 Other ICD-10: _____
Current Signed and Dated Documents Required For Treprostinil Therapy Initiation:
 Right Heart Catheterization
 Echocardiogram
 History and Physical Including: Onset of Symptoms, PAH Clinical Signs and Symptoms, Need for Specific Drug Therapy, Course of Illness
 Treatment History (included on the next page)
 Transition Statement (if applicable)
 Calcium Channel Blocker Statement (included on the next page)

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 drugs)		
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		
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

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 the specialty pharmacy of your choice below.

STEP 4 FAX COVER SHEET

Date: _____

To: (check one)

Accredo
Fax: 1-800-711-3526
Phone: 1-866-344-4874

CVS Caremark
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
Step 4 - Optional Side Effect Management

Included signed and dated documents

- Right Heart Catheterization Results
History and Physical (including Onset of Symptoms, PAH Clinical Signs and Symptoms, Course of Illness)
Need for Specific Drug Therapy and 6-minute walk test results
Echocardiogram Results

Number of Pages: _____

Additional Comments:

