Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Tyvaso & Yutrepia (treprostinil) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage **Tyvaso & Yutrepia (treprostinil)** for **Commercial, Exchange, FEHB (Federal),** and **MD Medicaid** plans. Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**
KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

If consulted with a specialist, specialist name and specialty: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?
□ Yes – please provide your provider referral number here: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, State date: _____

2. Indicate the Member's diagnosis for the requested medication: _____

Clinical Criteria:

1. Is the prescriber a Pulmonologist or Cardiologist?
   □ No □ Yes

2. <u>If ordering Tyvaso:</u> Does the patient have history of treatment failure/inadequate response, intolerance, or contraindication to Yutrepia (treprostinil)?
   □ No □ Yes

<u>If using for pulmonary arterial hypertension:</u>

3. Does the member have a diagnosis of pulmonary arterial hypertension (PAH) [World Health Organization (WHO) Group I?
   □ No □ Yes

4. Does the member currently have WHO Functional Class II, III or IV symptoms?
   □ No □ Yes

5. Is patient currently taking, or has documented treatment failure, intolerance, or contraindication to at least two of the following?
   a. A phosphodiesterase type (PDE-5) inhibitor (e.g. sildenafil, tadalafil)
   b. An endothelin receptor antagonist (ERA) [(e.g. ambrisentan, bosentan, macitentan (Opsumit)]
   c. A soluble guanylate cyclase stimulator [e.g., riociguat (Adempas)]
   □ No □ Yes

6. Does provider attest that patient will NOT be using this medication with another prostanoid/prostacyclin analogue (e.g., IV epoprostenol, IV/subcut/inhaled/PO treprostinil, PO selexipag)?
   □ No □ Yes

<u>If using for pulmonary hypertension associated with interstitial lung disease:</u>

7. Does the patient have a diagnosis of pulmonary hypertension associated with interstitial lung disease (PH-ILD) (WHO Group 3) verified by right heart catheterization?
   □ No □ Yes

*Note: Orenitram (treprostinil ER oral) is more cost-effective than Tyvaso (treprostinil inhalation) and Uptravi (selexipag) at doses **less than** 6.5 mg TID*

For Continuation of Therapy, Please Respond to Additional Questions Below. New members who were initiated on therapy outside of Kaiser, who have not been reviewed previously, must meet all above Clinical Criteria.

1. Does the patient continue to be under the care of a Pulmonologist or Cardiologist, and has had follow-up since last review?
   □ No □ Yes

2. Is there documentation the member is experiencing clinical benefit from therapy as evidenced by disease stability or disease improvement?
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**