Tyvaso® (treprostinil inhalation solution) Medication Precertification Request

(All fields must be completed and legible for Precertification Review)

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy, Date of last treatment ____/____/____

Precertification Requested By: ______________________ Phone: ____________ Fax: ____________

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:
Address:	City:	State: ZIP:
Home Phone: Work Phone:	Cell Phone:	Email:

Patient Current Weight: _______ lbs or _______ kgs Patient Height: _______ inches or _______ cms Allergies:

B. INSURANCE INFORMATION

Aetna Member ID #: ____________
Group #: ____________
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: ____________ Carrier Name: ____________
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:	Last Name:	*(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.
Address:	City:	State: ZIP:
Phone: Fax:	St Lic #: NPI #:	DEA #: UPIN:
Provider Email:	Office Contact Name:	Phone:

Specialty *(Check one)*: ☐ **Cardiologist** ☐ **Pulmonologist** ☐ **Other**: ____________

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: ____________
Center Name: ____________
☐ Home Infusion Center Phone: ____________
Agency Name: ____________
☐ Administration code(s) (CPT): ____________
Address: ____________

Dispensing Provider/Pharmacy: *(Patient selected choice)*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: ____________
Name: ____________
Address: ____________
Phone: ____________ Fax: ____________
TIN: ____________ PIN: ____________

E. PRODUCT INFORMATION

Request is for: Tyvaso (treprostinil inhalation solution) Dose: ____________ **Frequency:** ____________

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: ____________ Other: ____________

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For Initiation Requests (clinical documentation required):

Please indicate the World Health Organization (WHO) classification of pulmonary hypertension:
Select one: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

☐ Yes ☐ No Does the patient have pulmonary hypertension associated with interstitial lung disease?
☐ Yes ☐ No Has PH been confirmed by right heart catheterization?
→ (No) ☐ Yes ☐ No Is the patient an infant less than one year of age?
☐ Yes ☐ No Has Doppler echocardiogram been performed to diagnose PH?
→ (Yes) Please indicate the pretreatment mean pulmonary arterial pressure results: ☐ less than or equal to 20mmHg ☐ greater than 20mmHg
Please indicate the pretreatment pulmonary capillary wedge pressure: ☐ less than or equal to 15 mmHg ☐ greater than 15 mmHg
Please indicate the pretreatment pulmonary vascular resistance: ☐ less than 3 Wood units ☐ greater than or equal to 3 Wood units

For Continuation Requests (clinical documentation required):

☐ Yes ☐ No Is the patient experiencing benefit from therapy as evidenced by disease stability or disease improvement?
→ Please select: ☐ disease stability ☐ disease improvement

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required)*: ______________________ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.