Referral Form for TYVASO (treprostinil) and TYVASO DPI (treprostinil)

Tyvaso and Tyvaso DPI are available only through select Specialty Pharmacy Services (SPS) providers.
Follow these 5 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, Medical Information, and Treatment History and Transition Statement.
- ☐ 3 Complete and sign the Prescription Information, Statement of Medical Necessity for either **PH-ILD** or **PAH**, and Calcium Channel Blocker Statement (CCB 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. Use the included **Fax Cover Sheet** 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: ☐ Home ☐ Cell ☐ Work | Alternate Telephone: ☐ Home ☐ Cell ☐ Work | Best Time to Call: ☐ Morning ☐ Afternoon ☐ Evening

Okay to leave a voicemail? ☐ Yes ☐ No

E-mail Address

Caregiver/Family Member | Caregiver Telephone: ☐ Home ☐ Cell ☐ Work | Caregiver Alternate Telephone: ☐ Home ☐ Cell ☐ Work

Caregiver E-mail Address | Caregiver Alternate E-mail Address | Okay to leave a voicemail? ☐ Yes ☐ No

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 medical and prescription insurance card(s).

Patient Name: _____ **Date of Birth:** _____

STEP 2 PRESCRIBER INFORMATION

Prescriber Name - First Last NPI # State License #

Office/Clinic/Institution Name Office Contact Name

Address City State Zip

Office Contact Phone Fax Office Contact E-mail

Preferred Method of Communication: ☐ Phone ☐ E-mail ☐ Mail ☐ Fax

STEP 2 MEDICAL INFORMATION / PATIENT EVALUATION / SUPPORTING DOCUMENTATION

Patient Product Therapy Status for the Requested Drug:
☐ Naïve/New ☐ Restart ☐ Transition

Current Specialty Pharmacy:
☐ CVS Specialty

Patient Status:
☐ Outpatient ☐ Inpatient

WHO Group: _____

NYHA Functional Class (PAH Only):
☐ I ☐ II ☐ III ☐ IV

Weight:_____ ☐ kg ☐ lb
Height: ___ft___in

Diabetic:
☐ Yes ☐ No

Allergies:
☐ Drug Allergies ☐ Non-Drug Allergies ☐ No Known Allergies

Current Signed and Dated Documents Required for Treprostinil Therapy Initiation:

☐ Right Heart Catheterization ☐ Echocardiogram (not required for PH-ILD patients) ☐ High-Resolution CT Scan (not required for PAH patients)
☐ Treatment History (below) ☐ 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

STEP 2 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 (not required for PH-ILD patients)
It is necessary for this patient (if applicable) to transition
FROM _____ **TO** _____
Please provide justification for this transition.

_____
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STEP 2 PRESCRIBER SIGNATURE

SIGN HERE

Prescriber Name: _____ **Prescriber Signature:** _____ **Date:** _____

Patient Name: _____ **Date of Birth:** _____

STEP 3 PH-ILD - USE THIS SECTION FOR PH-ILD

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

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

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 daily - Start with 3 breaths (18 mcg) 4 times daily (if 3 breaths are not tolerated, use 1 to 2 breaths). Increase by an additional 1 breath per week, if tolerated, until the target dose of 9 breaths (54 mcg) to 12 breaths (72 mcg), 4 times daily.

☐ TYVASO Inhalation System Starter Kit (28-day supply) 0 refills

☐ TYVASO Inhalation System Refill Kit (28-day supply) X _____ refills

Prescriber may specify any alternative or additional dosing and titration instructions here:

_____

OR

TYVASO DPI (treprostinil) Inhalation Powder

Target dose: ☐ 48 mcg or ☐ 64 mcg or ☐ Other _____ mcg per treatment session, 4 times daily (Check One)

Start with one 16-mcg cartridge per treatment session, 4 times daily. Increase cartridge strength by 16 mcg per treatment session every week to selected target dose. Titration schedule may vary based on tolerability. If the prescribed dose is higher than 64 mcg per treatment session, more than 1 cartridge will be needed per session.

TYVASO DPI Titration Kit (28-day supply) Choose one for titration phase.

☐ 16 mcg (112 ct) and 32 mcg (84 ct) 0 refills

☐ 16 mcg (112 ct), 32 mcg (112 ct), and 48 mcg (28 ct) 0 refills

TYVASO DPI Maintenance Kit (28-day supply) X _____ refills

Inhale one breath per cartridge, 4 times daily. Please check all boxes to allow maintenance dose at the highest dose tolerated, unless otherwise specified.

☐ 16 mcg (112 ct) ☐ 32 mcg (112 ct) ☐ 48 mcg (112 ct) ☐ 64 mcg (112 ct) ☐ 80 mcg combination: 32 mcg (112 ct) and 48 mcg (112 ct)

Prescriber may specify any alternative or additional dosing and titration instructions here. If the prescribed dose is higher than 64 mcg per treatment session, more than 1 cartridge will be needed per session:

_____

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

Dose Comparison

TYVASO Nebulizer # of Breaths	TYVASO DPI Cartridge Strength
≤5	16 mcg
6 to 7	32 mcg
8 to 10	48 mcg
11 to 12	64 mcg
~15	80 mcg

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.

CHECK ONE **Nurse Visits**

☐ **Specialty Pharmacy home healthcare RN visit** to provide education on self-administration of Tyvaso or Tyvaso DPI, including dose, titration, and side effect management.

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

_____

_____

STEP 3 PRESCRIBER SIGNATURE: PRESCRIPTION AND STATEMENT OF MEDICAL NECESSITY

SIGN HERE

I certify that the pulmonary hypertension associated with interstitial lung disease 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: _____ _____ **Date:** _____

Dispense as Written **Substitution Allowed**

DAW

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

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

Patient Name: _____ **Date of Birth:** _____

STEP 3 PAH - USE THIS SECTION FOR PAH

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: ☐ Idiopathic PAH ☐ Heritable PAH

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

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 daily - Start with 3 breaths (18 mcg) 4 times daily (if 3 breaths are not tolerated, use 1 to 2 breaths). Increase by an additional 3 breaths every week, if tolerated, until the target dose of 9 breaths (54 mcg) to 12 breaths (72 mcg), 4 times daily.

☐ TYVASO Inhalation System Starter Kit (28-day supply) 0 refills

☐ TYVASO Inhalation System Refill Kit (28-day supply) X _____ refills

Prescriber may specify any alternative or additional dosing and titration instructions here:

_____

OR

TYVASO DPI (treprostinil) Inhalation Powder

Target dose: ☐ 48 mcg or ☐ 64 mcg or ☐ Other _____ mcg per treatment session, 4 times daily (Check One)

Start with one 16-mcg cartridge per treatment session, 4 times daily. Increase cartridge strength by 16 mcg per treatment session every week to selected target dose. Titration schedule may vary based on tolerability. If the prescribed dose is higher than 64 mcg per treatment session, more than 1 cartridge will be needed per session.

TYVASO DPI Titration Kit (28-day supply) Choose one for titration phase.

☐ 16 mcg (112 ct) and 32 mcg (84 ct) 0 refills

☐ 16 mcg (112 ct), 32 mcg (112 ct), and 48 mcg (28 ct) 0 refills

TYVASO DPI Maintenance Kit (28-day supply) X _____ refills

Inhale one breath per cartridge, 4 times daily. Please check all boxes to allow maintenance dose at the highest dose tolerated, unless otherwise specified.

☐ 16 mcg (112 ct) ☐ 32 mcg (112 ct) ☐ 48 mcg (112 ct) ☐ 64 mcg (112 ct) ☐ 80 mcg combination: 32 mcg (112 ct) and 48 mcg (112 ct)

Prescriber may specify any alternative or additional dosing and titration instructions here. If the prescribed dose is higher than 64 mcg per treatment session, more than 1 cartridge will be needed per session:

_____

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

Dose Comparison

TYVASO Nebulizer # of Breaths	TYVASO DPI Cartridge Strength
≤5	16 mcg
6 to 7	32 mcg
8 to 10	48 mcg
11 to 12	64 mcg
~15	80 mcg

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.

CHECK ONE **Nurse Visits**

☐ **Specialty Pharmacy home healthcare RN visit** to provide education on self-administration of Tyvaso or Tyvaso DPI, including dose, titration, and side effect management.

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

_____

_____

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

☐ 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

☐ Other: _____

OR

The following Calcium Channel Blocker was trialed: _____

With the following response(s):

☐ Patient hypersensitive or allergic _____

☐ Adverse event

☐ Pulmonary arterial pressure continued to rise

☐ Patient became hemodynamically unstable

☐ Disease continued to progress or patient remained symptomatic _____

☐ Other: _____

STEP 3 PRESCRIBER SIGNATURE: PRESCRIPTION AND STATEMENT OF MEDICAL NECESSITY

SIGN HERE

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: _____ **Date:** _____

DAW

_____ **Dispense as Written** _____ **Substitution Allowed**

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

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

Patient Name: _____ **Date of Birth:** _____

STEP 4 OPTIONAL SIDE EFFECT MANAGEMENT

By providing your side effect management strategies, SPS will be able to follow up with the patient should they experience side effects. Include directions to SPS for dosing in Step 3 of this form.

***INFORMATION PROVIDED BELOW IS NOT A PRESCRIPTION; RATHER, IF ADDITIONAL PRESCRIPTIONS ARE INTENDED, THEY SHOULD BE PROVIDED TO THE PATIENT SEPARATELY.**

Headache:

☐ Acetaminophen _____ mg _____ Frequency ☐ Opioids **(separate Rx required)** ☐ Tramadol **(separate Rx required)**

☐ NSAIDs **(separate Rx may be required)**

☐ Other _____

Nausea/Vomiting:

☐ Ondansetron **(separate Rx required)** ☐ Metoclopramide **(separate Rx required)** ☐ PPIs **(separate Rx may be required)**

☐ Prochlorperazine **(separate Rx required)** ☐ Promethazine **(separate Rx required)**

☐ Remind patient to hold the device level and swish & spit after each treatment session

☐ Other _____

Throat Irritation:

☐ Oral phenol-based analgesic sprays ☐ Review medication administration technique

☐ Other _____

Cough:

☐ Albuterol **(separate Rx required)** ☐ Benzonatate **(separate Rx required)** ☐ Cough suppressant **(separate Rx may be required)**

☐ Oral phenol-based analgesic sprays ☐ Lozenges **(note: not to be used during treatment session)** ☐ Inhaled anticholinergics **(separate Rx required)**

☐ Inhaled steroids **(separate Rx required)** ☐ Other _____

Diarrhea:

☐ Loperamide **(separate Rx required)** ☐ Other _____

Additional Instructions:

Provide any additional instructions for SPS on preferred communication or managing other side effects.

_____

_____

_____

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_____

_____

_____

Fax the completed referral form and documentation to your Specialty Pharmacy.

STEP 5 FAX COVER SHEET

Date: _____ **Patient Initials:** _____ **Patient Date of Birth:** _____

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 and Tyvaso DPI Therapy Referral Form including**

- Step 1 - Patient Information and Insurance Information (including front and back copies of medical and prescription insurance card(s))
- Step 2 - Prescriber Information, Medical Information/Patient Evaluation/Supporting Documentation, and Treatment History and Transition Statement
- Step 3 - Prescription Information and Calcium Channel Blocker Statement (CCB 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
- High-Resolution CT Scan (not required for PAH patients)

Number of Pages: _____

Additional Comments:

_____
_____
_____
_____
_____
_____
_____
_____

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