

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
E-mail Address		Okay to leave a voicemail? Yes No
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		
Subscriber ID #	Group #	Telephone
Secondary Medical Insurance		
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: Naive/New Restart Transition			Current Specialty Pharmacy: Accredo Health Group, Inc.		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		
Upravi® (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.

STEP 2 PRESCRIBER SIGNATURE



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

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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.

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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
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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
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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 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 is hemodynamically unstable or has a history of postural hypotension
- Patient has systemic hypotension
- Patient did not meet ACCP Guidelines for Vasodilator Response
- Patient has known hypersensitivity
- 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 _____ Pulmonary arterial pressure continued to rise
- Adverse event _____ Patient became hemodynamically unstable
- Disease continued to progress or patient remained symptomatic _____
- Other: _____

STEP 3 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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Fax the completed referral form and documentation to your Specialty Pharmacy.

STEP 5 FAX COVER SHEET

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

To: Accredo Health Group, Inc.
Fax: 1-800-711-3526
Phone: 1-866-344-4874

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:

Multiple horizontal lines for additional comments.

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