USFHP Prior Authorization Request Form for iloprost inhalation (**Ventavis**), treprostinil inhalation (**Tyvaso**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? Call 1-877-880-7007

https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Clinical documentation may be required

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #:		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Is the requested medication being prescribed by or in consultation with a cardiologist or a pulmonologist?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. What is the indication or diagnosis?	☐ WHO group 1 pulmonary arterial hypertension (PAH) - Proceed to question **4** ☐ WHO group 3 pulmonary hypertension associated with interstitial lung disease (PH-ILD) Proceed to question **3** ☐ Other - **STOP Coverage not approved**	
3. What is the requested medication?	☐ Ventavis – **STOP Coverage not approved** ☐ Tyvaso - **Sign and date below**	
4. Has the patient had a right heart catheterization?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is documentation being provided to confirm that the patient has had a right heart catheterization? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Documentation may include, but is not limited to, chart notes and catheterization laboratory reports.	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6.Did the results of the right heart catheterization confirm the diagnosis of WHO Group 1 PAH?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____