P.O. Box 30192
Salt Lake City, UT 84130-0192
801-442-4912 or 800-442-3219
Fax 801-442-3006

selecthealth℠

# PREAUTHORIZATION FORM

Flolan®, Remodulin®, Ventavis®, and Tyvaso™
(Epoprostenol, Treprostinil, Iloprost, and Treprostinil)

**Therapeutic use:** Treatment of pulmonary arterial hypertension (PAH) not responding to conventional therapy

**Quantity Limit:**

- Flolan: 2 ng/kg/min continuous IV infusion, titrated upward by 2 mg/kg/min each fifteen minutes until dose-limiting effects occur
- Remodulin: 1.25 ng/kg/min continuous SC infusion, titrated upward; minimal experience with doses greater than 40 ng/kg/min
- Ventavis: 5 mcg inhaled 6 to 9 times daily
- Tyvaso: 3 to 9 inhaltions (18 mcg – 54 mcg) every 4 hours

**Authorization Period:** 1 year

Patient's name _____

Patient's ID# ☐☐☐ ☐☐ ☐☐☐☐ DOB ☐☐/☐☐/☐☐☐☐

ICD-9 ☐☐☐ ☐☐ ☐☐☐ ☐☐ _____

Physician's name_____

Physician's Ph# (☐☐☐) ☐☐☐-☐☐☐☐ Fax# ☐☐☐-☐☐☐☐

Physician's signature_____ Date signed ☐☐/☐☐/☐☐☐☐

Supervising Physician's name_____ (Required if requesting provider is a nurse practitioner or physician assistant)

| Please check "Yes" or "No" or answer the following questions: | | | |
|---|---|---|---|
| 1. | Which medication is being requested? ❑ Flolan ❑ Remodulin ❑Ventavis ❑Tyvaso | | |
| 2. | Is the prescribing physician a specialist who evaluates and treats pulmonary hypertension (i.e., pulmonologist for adults, cardiologists for pediatrics)? | ❑ Yes | ❑ No |
| 3. | What is the patient's NYHA functional class? ❑ II ❑ III ❑ IV | | |
| 4. | Has the patient failed other PAH therapies? | ❑ Yes | ❑ No |

Please list other therapies that have been tried in the table below.

| Name of Drug | Duration of Therapy | Reason for Discontinuation |
|---|---|---|
| a. | | |
| b. | | |
| c. | | |

**This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.**

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