Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Tyvaso

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the patient currently receiving the requested medication?

☐ Yes ☐ No

Q2. Is the patient experiencing benefit from therapy as evidenced by disease stability or disease improvement?

☐ Yes ☐ No

Q3. Does the patient have one of the following: A) WHO Group 1 class of pulmonary hypertension (PH); B) Pulmonary hypertension associated with interstitial lung disease (WHO Group 3)?

☐ Yes ☐ No

Q4. Has the diagnosis of pulmonary hypertension been confirmed by either criterion (a) or criterion (b) below:
A) Pretreatment right heart catheterization with all of the following results: i. mPAP > 20 mmHg; ii. PCWP ≤ 15 mmHg;
iii. PVR ≥ 3 Wood units)

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Patient Name:	**Prescriber Name:**

b) For infants less than one year of age, PH was confirmed by Doppler echocardiogram if right heart catheterization cannot be performed?

☐ Yes ☐ No

Q5. Additional Information:

_____ _____

Prescriber Signature Date

v2025