

Tyvaso (treprostinil) and Ventavis (iloprost)



Prior Authorization Request (Physician to Complete)

Visit www.wellmark.com for the Wellmark Drug List for current medication tier levels and updated PA Forms

Facsimile Transmittal Sheet

Date: ____/____/____

To: Wellmark Pharmacy Services

From (Prescriber's Name): _____

Fax Number: (866) 884-4345

Prescriber's DEA Number: _____

Phone Number: (800) 600-8065

Prescriber's Phone Number: _____

Prescriber's Specialty: _____

Prescriber's Fax Number: _____

Prescriber's Office Address: _____
Street Suite # City State Zip

Patient Name: _____

Patient ID _____ Patient DOB: ____/____/____

Please answer the following questions and fax this form back to (866) 884-4345. All fields are REQUIRED.

1. Does the patient currently have a diagnosis of WHO Group 1 pulmonary arterial hypertension (PAH)?
Yes No

ICD-9 Code: _____

2. Which drug is being requested? Tyvaso Ventavis

3. Has the patient's PAH progressed despite maximal medical treatment(s) of the underlying condition?

Yes No

4. Drug Strength: _____ mg/mL or mcg/mL Quantity/30 day _____ units

Directions: _____

Printed Name

Signature

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