



**TEXAS MEDICAID - CHIP
Drug Prior Authorization
treprostinil (TYVASO STARTER KIT)**

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: INDICATE MEDICATION REQUESTED AND APPROPRIATE DIAGNOSIS
<input type="checkbox"/> TYVASO STARTER KIT for a patient newly starting TYVASO AND <input type="checkbox"/> Diagnosis of Pulmonary Arterial Hypertension (PAH) (ICD 10 Code: I27.0)

STEP 3: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: 855-668-8553
Prescriber Signature: _____ Date: _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.