Texas - 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

☐ TYVASO STARTER KIT for a patient newly starting TYVASO

AND ☐ Diagnosis of Pulmonary Arterial Hypertension (PAH) **(ICD 10 Code: I27.0)**

STEP 3: SUBMISSION - SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553 (toll free) or 920-735-5312 (local)**

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