TRICARE Prior Authorization Request Form for
treprostinil sodium (**Yutrepia**)

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HEALTH PLANS
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Fax completed form and applicable progress notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization does not expire.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID #: _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the requested medication being prescribed by or in consultation with a cardiologist or a pulmonologist?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. What is the indication or diagnosis?	☐ WHO group 1 pulmonary arterial hypertension (PAH) - Proceed to question **3** ☐ WHO group 3 pulmonary hypertension associated with interstitial lung disease (PH-ILD) - **Sign and date below** ☐ Other - **STOP Coverage not approved**	
3. Has the patient had a right heart catheterization?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is documentation being provided to confirm that the patient has had a right heart catheterization? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Documentation may include, but is not limited to, chart notes and catheterization laboratory reports.	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**

	5. Did the results of the right heart catheterization confirm the diagnosis of WHO Group 1 PAH?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[15 July 2025]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: