# PREFERRED SPECIALTY MANAGEMENT POLICY

**POLICY:** Pulmonary Arterial Hypertension and Related Lung Disease – Inhaled Prostacyclin Products Preferred Specialty Management Policy

- Tyvaso® (treprostinil inhalation solution – United Therapeutics)
- Tyvaso DPI™ (treprostinil inhalation powder – United Therapeutics/Mannkind)
- Ventavis® (iloprost inhalation solution – Actelion/Janssen)

**REVIEW DATE:** 10/12/2022; selected revision 11/30/2022

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## OVERVIEW

Tyvaso, Tyvaso DPI, and Ventavis are inhaled prostacyclin vasodilators (prostacyclin mimetics) indicated for the treatment of:[1-3]

- **Pulmonary arterial hypertension (PAH), World Health Organization (WHO) Group 1**. Tyvaso and Tyvaso DPI are specifically indicated to improve exercise ability whereas Ventavis is indicated to improve a composite endpoint consisting of exercise tolerance, symptoms, and lack of deterioration.

Tyvaso and Tyvaso DPI are also indicated for:[1]

- **Pulmonary hypertension associated with interstitial lung disease (WHO Group 3)**. Tyvaso and Tyvaso DPI are indicated to improve exercise ability for this population.

## POLICY STATEMENT

This Preferred Specialty Management program has been developed to encourage the use of the Preferred Product(s). For all Medications (Preferred and Non-Preferred), the patient is required to meet the respective Prior Authorization Policy criteria. The program also directs the patient to try one Preferred Product prior to the approval of a Non-Preferred Product. Requests for Non-Preferred Products will also be reviewed using the exception criteria (below). All approvals are provided for 1 year in duration. If the patient meets the standard *Pulmonary Arterial Hypertension and Related Lung Disease – Inhaled Prostacyclin Products Prior Authorization Policy* criteria but has not tried the Preferred Product, approval for the Preferred Product(s) will be authorized.

**Automation:** None.

**Preferred Product:** Tyvaso, Tyvaso DPI
**Non-Preferred Product:** Ventavis

## RECOMMENDED EXCEPTION CRITERIA

| Non-Preferred Product | Exception Criteria |
|---|---|
| Ventavis | **1.** Approve for 1 year if the patient meets both of the following (A and B):<br>**A)** Patient meets the standard *Pulmonary Arterial Hypertension – Inhaled Prostacyclin Products Prior Authorization Policy* criteria; AND<br>**B)** Patient meets one of the following (i, ii, or iii):<br>**i.** Patient has been established on Ventavis; OR<br>**ii.** Patient has tried Tyvaso or Tyvaso DPI; OR<br>**iii.** Patient already has the device for Ventavis.<br>**2.** For a patient who meets the standard *Pulmonary Arterial Hypertension and Related Lung Disease – Inhaled Prostacyclin Products Prior Authorization Policy* criteria but does not meet 1B, approve the Preferred Product. |

## REFERENCES

1. Tyvaso® inhalation solution [prescribing information]. Research Triangle Park, NC: United Therapeutics; May 2022.
2. Ventavis® inhalation solution [prescribing information]. Titusville, NJ: Actelion/Janssen; March 2022.
3. Tyvaso DPI™ oral inhalation powder [prescribing information]. Danbury, CT and Research Triangle Park, NC: MannKind and United Therapeutics; May 2022.