maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Tarpeyo

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	Is the patient greater than or equal to 18 year(s) of age? [If no, no further questions.]	Yes	No
2	What is the indication or diagnosis? [] Primary immunoglobulin A nephropathy (IgAN) (If checked, go to 3) [] Other (If checked, no further questions)		
3	Has the diagnosis of primary immunoglobulin A nephropathy (IgAN) been confirmed by biopsy? [If no, no further questions.]	Yes	No

If you have any questions, call:
1-888-258-8250

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4	Has the patient been receiving the maximum or maximally tolerated dose of ONE of the following for greater than or equal to 90 days: A) Angiotensin converting enzyme inhibitor OR B) Angiotensin receptor blocker? [If no, no further questions.]	Yes	No
5	According to the prescriber, has the patient received greater than or equal to 90 days of optimized supportive care, including blood pressure management, lifestyle modification, and cardiovascular risk modification? [If no, no further questions.]	Yes	No
6	Does the patient have an estimated glomerular filtration rate greater than or equal to 30 mL/min/1.73 m^2? [If no, no further questions.]	Yes	No
7	Does the patient have severe hepatic impairment (Child-Pugh Class C)? [If yes, no further questions.]	Yes	No
8	Does the prescribed dosing exceed FDA approved indication? [If yes, no further questions.]	Yes	No
9	Is the requested medication being prescribed by or in consultation with a nephrologist? [If no, no further questions.]	Yes	No
10	Is the patient currently receiving the requested medication? [If yes, skip to question 12.]	Yes	No
11	Has the patient previously been treated with Tarpeyo? [If yes, no further questions.] [If no, skip to question 16.]	Yes	No
12	Will the patient exceed 10 consecutive months of therapy? [If yes, no further questions.]	Yes	No
13	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 16.]	Yes	No
14	Does the patient have a previously approved PA on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If yes, skip to question 19.]	Yes	No
15	Has the patient been established on therapy and has had a documented clinically significant response, as determined by the provider? [If no, no further questions.]	Yes	No

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16	Is the patient at high risk of disease progression, defined by meeting the following criteria: A) Proteinuria greater than 0.75 g/day OR B) Urine protein-to-creatinine ratio greater than or equal to 1.5 g/g? [If no, no further questions.]	Yes	No
17	Does the patient have a history of failure, contraindication or intolerance to TWO glucocorticoids used for at least 2 months? [If no, no further questions.]	Yes	No
18	Is the patient currently receiving the requested medication? [If no, no further questions.]	Yes	No
19	How many consecutive months of therapy has the patient received? [Reviewer Note: Approval is not to exceed 10 consecutive months. (for example, if a patient has received 3 consecutive months approve 7 months to complete 10 consecutive months of therapy.)] [] 10 or more (If checked, no further questions) [] 9 (If checked, no further questions) [] 8 (If checked, no further questions) [] 7 (If checked, no further questions) [] 6 (If checked, no further questions) [] 5 (If checked, no further questions [] 4 (If checked, no further questions) [] 3 (If checked, no further questions) [] 2 (If checked, no further questions) [] 1 or less (If checked, no further questions)		

Please document the diagnoses, symptoms, and/or any other information important to this review:

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SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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If you have any questions, call: 1-888-258-8250