maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Tryvio

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 18 years of age or older? [If no, no further questions.]	Yes	No
2	Is the patient currently receiving Tryvio? [If no, skip to question 8.]	Yes	No
3	Does the patient have a previously approved prior authorization (PA) on file with the current plan for Tryvio? [If no, skip to question 8.]	Yes	No
4	Has the patient been diagnosed with treatment resistant hypertension (systolic blood pressure [SBP] greater than or equal to 140 mmHg)? ACTION REQUIRED:	Yes	No

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

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	Submit supporting documentation. [If no, no further questions.]		
5	Will Tryvio be used in combination with at least 3 other antihypertensive medications? [Reviewer Note: Please check claims history to confirm.] [If no, no further questions.]	Yes	No
6	Has the patient been established on therapy for at least 3 months? [If no, skip to question 8.]	Yes	No
7	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? [No further questions.]	Yes	No
8	Has the patient been diagnosed with treatment resistant hypertension (systolic blood pressure [SBP] greater than or equal to 140 mmHg)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
9	Will Tryvio be used in combination with at least 3 other antihypertensive medications? [Reviewer Note: Please check claims history to confirm.] [If no, no further questions.]	Yes	No
10	Does the patient have renal impairment, defined as estimated glomerular filtration rate (eGFR) less than 15 mL/min or is receiving dialysis? ACTION REQUIRED: Submit supporting documentation. [If yes, no further questions.]	Yes	No
11	Does the patient have moderate to severe hepatic impairment (Child-Pugh class B and C)? [If yes, no further questions.]	Yes	No
12	Does the provider attest to being enrolled in the Tryvio Risk Evaluation and Mitigation Strategies (REMS) program?	Yes	No

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.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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