maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Tryngolza

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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 Is the request an INITIAL or CONTINUATION of therapy?

[] Initial (If checked, go to 9)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 9.]

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

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3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 9.]	Yes	No
4	Does the patient have a previously approved prior authorization (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 no, skip to question 9.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 9.]	Yes	No
6	Is the patient continuing to adhere to a very low-fat diet (less than or equal to 20 grams of fat per day)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
7	Is the patient continuing to use a maximum tolerated dose of statins, omega-3 fatty acids, fibrates, or other lipid-lowering medications? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
8	Has documentation been submitted to confirm that the patient has had a clinically significant reduction in triglyceride levels from baseline from therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
9	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
10	Does the patient have a diagnosis of familial chylomicronemia syndrome (FCS)? [If no, no further questions.]	Yes	No
11	Has the diagnosis been confirmed by genetic testing demonstrating a pathogenic mutation in one of the following genes: *LPL, APOC2, APOA5, GPIHBP1, or LMF1*? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
12	Does the patient have documented diagnostic testing that supports familial chylomicronemia syndrome (FCS) diagnosis? (FCS Score greater than or equal to 10 or NAFCS Score greater than or equal to 45)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
13	Does the patient have a documented fasting triglyceride level greater than or equal to 880 mg per dL within the last 2 months? ACTION REQUIRED: Submit supporting documentation.	Yes	No

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	[If no, no further questions.]		
14	Will the requested medication be used as an adjunct to a very low-fat diet (less than or equal to 20 grams of fat per day)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	Is the patient currently using a maximum tolerated dose of statins, omega-3 fatty acids, fibrates, and other lipid-lowering medications for more than 3 months and the triglyceride level is still greater than or equal to 880 mg per dL? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
16	Has the patient had an acute coronary syndrome within the last 6 months? [If yes, no further questions.]	Yes	No
17	Has the patient had any major surgery within the last 3 months? [If yes, no further questions.]	Yes	No
18	Is the requested medication prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist? [If no, no further questions.]	Yes	No
19	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication?	Yes	No

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

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,

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