



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. 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 this request for initial therapy or for a continuation of therapy?

Initial (If checked, go to 8)

Continuation (If checked, go to 2)

2 Is the patient currently receiving Tryvio? Yes No
 [If no, skip to question 8.]

**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 8.]	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 8.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 8.]	Yes	No
6	Is the patient pregnant or planning to become pregnant within the next month? [If yes, no further questions.]	Yes	No
7	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [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	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
10	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
11	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
12	Does the patient have moderate to severe hepatic impairment (Child-Pugh class B and C)? [If yes, no further questions.]	Yes	No
13	Is the patient pregnant or planning to become pregnant before initiation of treatment? [If yes, no further questions.]	Yes	No
14	Does the provider attest to being enrolled in the Tryvio Risk Evaluation and	Yes	No

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Mitigation Strategies (REMS) program?
[If no, no further questions.]

15 Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication? Yes No
[Note: Dosing: 12.5 mg once daily.]

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, 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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