

Request for Prior Authorization APROCITENTAN (TRYVIO)

FAX Completed Form To 1 (800) 574-2515 Provider Help Desk 1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name		DOB	
Patient address			<u> </u>	
Provider NPI	Prescriber name		Phone	
Prescriber address		Fax		
Pharmacy name	Address		Phone	
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.				
Pharmacy NPI	Pharmacy fax	NDC 		
Prior authorization (PA) is required for aprocitentan (Tryvio). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agents would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of resistant hypertension; and 3. Secondary causes of hypertension have been ruled out; and 4. Patient has been adherent with standard background antihypertensive therapy, which includes at least one agent from each of the following classes, taken concurrently at maximally tolerated doses: a. Angiotensin-converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB); b. Calcium channel-blockers (CCB); c. Diuretics; d. Mineralocorticoid receptor antagonist (MRA); and 5. Patient's blood pressure remains above target goal despite adherence with the above agents; and 6. Will be used in combination with at least three other antihypertensive agents at maximally tolerated doses. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.				
Non-Preferred Tryvio				
StrengthDosa	ge Instructions	Quantity	Days Supply	
Diagnosis:				
Document trials of at least one agent from each of the following classes taken concurrently at maximally tolerated doses:				
ACE or ARB Trial:				
Drug name & dose:		_Trial dates:		
Failure reason:				
CCB Trial:				
Drug name & dose:		_Trial dates:		
Failure reason:				

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Diuretics Trial:	
Drug name & dose:	_Trial dates:
Failure reason:	
MRA Trial:	
Drug name & dose:	_Trial dates:
Failure reason:	
Have secondary causes of hypertension been ruled out?	Yes
Does patient's blood pressure remain above target goal despir ☐ Yes ☐ No	te adherence with trial agents noted above?
Will medication be prescribed in combination with at least 3 of doses?	ther antihypertensive agents at maximally tolerated
Yes (document agents to be used, including dose):	
Medical or contraindication reason to override trial requirements:	
Attach lab results and other documentation as necessary.	
Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization, the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary, by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.

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