

SENTARA COMMUNITY PLAN MEDICAID

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-800-750-9692.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Tryvio™ (aproцитentan)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight (if applicable): _____ Date weight obtained: _____

Quantity Limit: 1 tablet per day

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 12 months

- Member is 18 years of age or older
- Member is currently receiving treatment at maximum or maximally tolerated doses with at least **ONE** agent from each of the classes below, unless contraindicated, for the past 4 weeks (**verified by pharmacy paid claims; documentation of intolerances or contraindications must be submitted; check all that apply**)
 - renin-angiotensin system (RAS) inhibitors (e.g., lisinopril, enalapril, losartan, valsartan)
 - calcium channel blockers (e.g., amlodipine, felodipine, nifedipine, verapamil)
 - thiazide/thiazide-like diuretics (e.g., hydrochlorothiazide, chlorthalidone, indapamide)

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- Treatment with a mineralocorticoid receptor antagonist (spironolactone, eplerenone) has been added to the existing antihypertensive regimen and was ineffective, intolerable, or is contraindicated (**verified by pharmacy paid claims; documentation of intolerance or contraindication must be submitted**)
- Treatment with an additional antihypertensive agent with a different mechanism of action (e.g., hydralazine, minoxidil, clonidine, prazosin, metoprolol) has been ineffective, or are all contraindicated (**verified by pharmacy paid claims; documentation of intolerance or contraindication must be submitted**)
- Provider must list the member's current prescribed antihypertensive drug regimen:

- Member has been adherent to prescribed antihypertensive drug regimen for at least 4 weeks prior to the date of the blood pressure reading recorded in chart note documentation (**adherence will be verified by pharmacy paid claims**)
- Provider has evaluated the member for causes of pseudoresistance (e.g., inaccurate blood pressure readings, white coat hypertension, secondary hypertension, non-adherence to medication) and confirms that pseudo-resistant hypertension has been ruled out
- Member has resistant hypertension as demonstrated by blood pressure above 130/80 mmHg, despite adherence to prescribed antihypertensive drug regimen (**submit documentation of blood pressure reading recorded within 30 days of request**)
- For patients who can become pregnant, all provider and patient-specific requirements of Tryvio™ REMS have been satisfied
- Provider attests baseline liver function tests and hemoglobin levels have been obtained and will be monitored periodically or as clinically indicated

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- Member's blood pressure has reduced from baseline after initiating therapy with Tryvio™ (**submit documentation**)
- Member is adherent to Tryvio™ and continues to receive Tryvio™ in addition to background antihypertensive drug therapy (**verified by pharmacy paid claims**)
- Provider attests hemoglobin and liver function tests continue to be monitored

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Medication being provided by Specialty Pharmacy – Proprium Rx

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.