IOWA Health and Human Services

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		
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

Strength_____ **Dosage 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 ☐ No

Does patient's blood pressure remain above target goal despite adherence with trial agents noted above?
☐ Yes ☐ No

Will medication be prescribed in combination with at least 3 other antihypertensive agents at maximally tolerated doses?

☐ Yes (document agents to be used, including dose): _____

_____

☐ No

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.*