TRICARE Prior Authorization Request Form for
budesonide (Tarpeyo)

JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization expires after 9 months. Please note Tarpeyo will be completely excluded from the TRICARE pharmacy benefit starting on 11/1/2023, regardless of how long the PA is approved.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: ______________________ Physician Name: ______________________
Address: ______________________ Address: ______________________
______________________ ______________________
Sponsor ID # ______________________ Phone #: ______________________
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

Question		
1. Provider acknowledges that Tarpeyo will be completely excluded from the Tricare Pharmacy Benefit starting on November 1st, 2023, regardless of how long the PA is approved.	☐ Acknowledged **Proceed to question 2**	
2. What is the patient's diagnosis or indication?	☐ Biopsy-verified primary immunoglobulin A nephropathy (IgAN) - **Proceed to question 3** ☐ Ulcerative colitis - **STOP Coverage not approved** ☐ Crohn's disease - **STOP Coverage not approved** ☐ Other - **STOP Coverage not approved**	
3. Is the requested medication prescribed by a nephrologist?	☐ Yes **Proceed to question 4**	☐ No **STOP** **Coverage not approved**
4. Does the patient have a urine protein-to-creatinine ratio UPCR greater than or equal to 1.5 g/g?	☐ Yes **Proceed to question 5**	☐ No **STOP** **Coverage not approved**
5. Has documentation been submitted to confirm that the patient is receiving a stable dose of a Renin-Angiotensin System inhibitor [ACE inhibitor or ARB (such as lisinopril, losartan, irbesartan)] at a maximally tolerated dose? **PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.**	☐ Yes **Proceed to question 6**	☐ No **STOP** **Coverage not approved**

6. Does the patient have an estimated glomerular filtration rate (eGFR) greater than or equal to 35ml/min?	☐ Yes **Proceed to question 7**	☐ No **STOP** **Coverage not approved**
7. Is the patient currently receiving renal dialysis or have they had a renal transplant?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 8**
8. The provider has considered use of a sodium-glucose-cotransportor2 (SGLT-2)-inhibitor (examples include empagliflozin and dapagliflozin).	☐ Acknowledged **Proceed to question 9**	
9. Has documentation been submitted to confirm that the patient has had a trial of an alternate oral glucocorticoid regimen for 6 months or immunosuppressive therapy and has failed therapy OR the patient has a contraindication? Examples include methylprednisolone, prednisolone/prednisone, Entocort EC or Uceris budesonide formulations. **PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.**	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature ____________________ Date ____________

[17 May 2023]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: