TRICARE Prior Authorization Request Form for
aprocitentan (Tryvio)

JOHNS HOPKINS
HEALTH PLANS

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

USFHP Pharmacy Prior Authorization Form

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 in one year. (Initial TRICARE PA approval required for renewal) Coverage will be approved indefinitely.

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:**

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? ***Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication.***	☐ Yes Proceed to question **10**	☐ No Proceed to question **2**
2. Is the patient 18 years of age or older?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is the requested medication being prescribed for the treatment of pulmonary arterial hypertension?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **4**
4. Is the requested medication being prescribed by a hypertension specialist (for example, internal medicine, cardiologist, nephrologist, or prescriber with certification from the American Society of Hypertension?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have a systolic blood pressure of GREATER THAN OR EQUAL TO 140 mmHg?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**

6. Has the patient tried AT LEAST THREE antihypertensive medications from the following classes one of which must be a diuretic, taken at maximally tolerated doses; Drug Classes include the following: **(a) diuretic,** **(b) renin-angiotensin system blockers (for example, ACE inhibitor or ARB blocker),** **(c) calcium channel blockers,** **(d) mineralocorticoid receptor blocker (for example, spironolactone)?**	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Is the patient a female of child-bearing age?	☐ Yes Proceed to question **8**	☐ No **Sign and date below**
8. Will the patient be tested for pregnancy?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Is the provider enrolled in the Risk Evaluation and Mitigation System (REMS) program?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
10. Has treatment with Tryvio controlled blood pressure within the patient's goal range?	☐ Yes Proceed to question 11	☐ No **STOP** **Coverage not approved**
11. Is the provider enrolled in the Risk Evaluation and Mitigation System (REMS) program?	☐ 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

[12 Feb 2025]

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