US Family Health Plan
Prior Authorization Request Form for
Aprocitentan (Tryvio)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior authorization expires in one year.
Initial USFHP PA approval required for renewal, 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:**

Question	Yes	No
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]