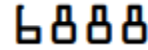


TRICARE Prior Authorization Request Form for
tenapanor (Xphozah)



To be completed and signed by the prescriber.



MARTIN'S POINT®
HEALTHCARE

**Clinical Documentation is required in order
for a determination to be made.**

Please fax completed form back to: (207) 828-7816

Prior authorization does not expire.

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. Is the patient 18 years of age or older?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Is the requested medication prescribed by or in consultation with a nephrologist?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. What is the indication or diagnosis? Note: Non-FDA approved uses are NOT approved, including constipation-predominant irritable bowel syndrome (IBS-C).	<input type="checkbox"/> Hyperphosphatemia in chronic kidney disease (CKD) - Proceed to question 4 <input type="checkbox"/> Other – STOP Coverage not approved	
4. Has the patient been receiving maintenance dialysis for at least 3 months?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
5. Is the patient's serum phosphate level greater than 5.5. mg/dL and less than 10 mg/dL?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No STOP Coverage not approved
6. Has the patient tried and had an inadequate response to at least two phosphate binders (for example, sevelamer (Renagel, Renvela), lanthanum (Fosrenol), ferric citrate (Auryxia), sucroferric oxyhydroxide (Velphoro), calcium carbonate, calcium acetate)?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 7

TRICARE Prior Authorization Request Form for
tenapanor (Xphozah)

7. Has the patient tried and been unable to tolerate at least two phosphate binders (for example, sevelamer (Renagel, Renvela), lanthanum (Fosrenol), ferric citrate (Auryxia), sucroferric oxyhydroxide (Velporo), calcium carbonate, calcium acetate)?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 8
8. Does the patient have a contraindication to at least two phosphate binders (for example, sevelamer (Renagel, Renvela), lanthanum (Fosrenol), ferric citrate (Auryxia), sucroferric oxyhydroxide (Velporo), calcium carbonate, calcium acetate). Contraindications to phosphate binders includes bowel obstruction, iron overload, or hypercalcemia?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 9
9. Has the patient had intolerance to any dose of phosphate binder therapy?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> 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

[8 May 2024]