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Angiotensin II receptor antagonist and combinations Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY HAVE BARCODES.

This form may be faxed to 844-403-1029.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP:	Office Street Address:		
Phone:			City:	State:	ZIP:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
	Directions for Use:	

Clinical Information (required)	
1. Select the diagnosis below: ❑ Cardiovascular risk reduction (**Micardis only**) ❑ Heart failure (**Diovan only**) ❑ Hypertension ❑ Hypertensive patient with left ventricular hypertrophy (**Cozaar and Hyzaar only**) ❑ Nephropathy in Type 2 diabetic patient (**Avapro and Cozaar only**) ❑ Post-myocardial infarction (**Diovan only**) ❑ Other diagnosis: _____ ICD-10 Code: _____	
2. Has the patient demonstrated a failure or intolerance to a majority (two or more in a class with at least two alternatives or one in a class with only one alternative) of the preferred formulary/preferred drug list alternatives for the given diagnosis (e.g., candesartan, eprosartan, irbesartan, losartan, telmisartan, valsartan, candesartan-HCT, irbesartan-HCT, losartan-HCT, telmisartan-HCT, valsartan-HCT, olmesartan and olmesartan-HCT)? If yes, please submit documentation, including medication(s) tried, dates of trial(s) and reason for treatment failure(s):_____	❑ Yes ❑ No
3. Does the patient have a documented contraindication to the listed formulary alternatives (e.g., candesartan, eprosartan, irbesartan, losartan, telmisartan, valsartan, candesartan-HCT, irbesartan-HCT, losartan-HCT, telmisartan-HCT, valsartan-HCT, olmesartan and olmesartan-HCT)? If yes, please submit documentation, including medication name(s) and contraindication:_____ _____	❑ Yes ❑ No
4. Has the patient had an adverse reaction OR would be reasonably expected to have an adverse reaction to a majority (two or more in a class with at least two alternatives or one in a class with only one alternative) of the listed formulary agents used for the requested indication (e.g., candesartan, eprosartan, irbesartan, losartan, telmisartan, valsartan, candesartan-HCT, irbesartan-HCT, losartan-HCT, telmisartan-HCT, valsartan-HCT, olmesartan and olmesartan-HCT)? If yes, please submit documentation, including medication name(s) and adverse reaction(s): _____ _____	❑ Yes ❑ No

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5. Does the patient have a clinical condition for which there is no listed formulary agent to treat the condition based on published guidelines or clinical literature? If yes, please submit documentation, including the clinical condition:_____	❑ Yes ❑ No
6. Is the drug being prescribed within the manufacturer's published dosing guidelines or does the dose fall within dosing guidelines found in accepted compendia or current literature (e.g., package insert, AHFS, Micromedex, current accepted guidelines, etc.)?	❑ Yes ❑ No

Information on this form is accurate as of this date.

Prescriber's Signature:	**Date:**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: **This request may be denied unless all required information is received.**
For more information about the prior authorization process, please contact us at 855-811-2218.
Monday – Friday: 8 a.m. to 1 a.m. Eastern, and Saturday: 9 a.m. to 6 p.m. Eastern