PRIOR AUTHORIZATION REQUEST
Entresto

PATIENT: Name_____
Address:_____
City, State, Zip_____
D.O.B._____
Member ID: _____

Prescriber: Name_____
Address_____
City, State, Zip_____
Phone _____
Fax_____
NPI _____

Medication Requested: *Entresto* **Qty Requested: _____**

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A Please answer the following questions

1. What is the diagnosis or indication?
   - ❑ Heart failure (NYHA Class II-IV)
   - ❑ All other indications or diagnoses ***(please specify):*** _____

2. ❑ Yes ❑No Does the patient have a reduced ejection fraction (HFrEF) of LESS THAN or EQUAL TO 40%?
3. ❑ Yes ❑No Is the requested medication being prescribed as replacement therapy for an ACEI (angiotensin-converting-enzyme inhibitor) and/or ARB (angiotensin receptor blocker) in a patient who is tolerating an ACEI or ARB?
4. ❑ Yes ❑No Is the requested medication being prescribed in combination with other heart failure therapies (such as beta blockers, aldosterone antagonist and combination therapy with hydralazine and isosorbide dinitrate)?
5. ❑ Yes ❑No Is the patient pregnant?
6. ❑ Yes ❑No Does the patient have severe hepatic impairment (Child Pugh Class C)?

Please document the diagnoses, symptoms, and/or any other information important to this review:

_____

_____

SECTION B Physician Signature

_____ _____
PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

If you have any questions, call: 800-753-2851