maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Entresto

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

1	Is the patient greater than or equal to 1 year(s) of age? [If no, no further questions.]	Yes	No
2	What is the diagnosis or indication? [] Chronic heart failure classified by one of the following New York Heart Association (NYHA) Class II, III or IV (If checked, go to 3) [] Treatment of symptomatic heart failure with systemic left ventricular systolic dysfunction in pediatric patients (If checked, go to 3) [] Other (If checked, no further questions)		

If you have any questions, call:
1-888-258-8250

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3	Does the patient have a reduced ejection fraction (HFrEF) of LESS THAN or EQUAL TO 40%? [If no, no further questions.]	Yes	No
4	Is the requested medication being prescribed in combination with an ACEI (angiotensin-converting-enzyme inhibitor) and/or ARB (angiotensin receptor blocker)? [If yes, no further questions.]	Yes	No
5	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)? [If no, no further questions.]	Yes	No
6	Is the patient diagnosed with diabetes? [If no, skip to question 8.]	Yes	No
7	Is the requested medication being prescribed in combination with aliskiren (Tekturna)? [If yes, no further questions.]	Yes	No
8	Is the patient female? [NOTE: A female is defined as an individual with the biological traits of a female, regardless of the individual's gender identity or gender expression.] [If no, skip to question 10.]	Yes	No
9	Is the patient pregnant? [If yes, no further questions.]	Yes	No
10	Does the patient have severe hepatic impairment (Child Pugh Class C)?	Yes	No

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

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

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FAX COMPLETED FORM TO: 1-833-896-0656

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.

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