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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the request for INITIAL or CONTINUATION of therapy? [] Initial (If checked, go to 7) [] Continuation (If checked, go to 2)		
2	Is the patient currently receiving the requested medication?	Yes	No

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

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	[If no, skip to question 7.]		
3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	Is the patient greater than or equal to 1 year(s) of age? [If no, no further questions.]	Yes	No
8	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 9) [] Treatment of symptomatic heart failure with systemic left ventricular systolic dysfunction in pediatric patients (If checked, go to 9) [] Other (If checked, no further questions)		
9	Does the patient have a reduced ejection fraction (HFrEF) of LESS THAN or EQUAL TO 40%? [If no, no further questions.]	Yes	No

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10	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
11	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
12	Is the patient diagnosed with diabetes? [If no, skip to question 14.]	Yes	No
13	Is the requested medication being prescribed in combination with aliskiren (Tekturna)? [If yes, no further questions.]	Yes	No
14	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 16.]	Yes	No
15	Is the patient pregnant? [If yes, no further questions.]	Yes	No
16	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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