

ANGIOTENSIN MODULATORS PRIOR AUTHORIZATION FORM

Please complete all applicable sections of this prior authorization request form and return to the fax number above. Please include all requested documentation (chart notes, laboratory data, etc.). To review the prior authorization guidelines for Angiotensin Modulators, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Angiotensin Modulators and Quantity Limits/Daily Dose Limits** (accessible at: <http://www.dhs.state.pa.us/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>.)

PRIOR AUTHORIZATION REQUEST INFORMATION			PRESCRIBER INFORMATION		
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request:	Prescriber name:		
<input type="checkbox"/> Renewal request	PA#: _____	_____			
Name of office contact:			Specialty:		
Contact's phone number:			State license #:		
LTC facility contact/phone:			NPI:	MA Provider ID#:	
RECIPIENT INFORMATION			Street address:		
Recipient Name:			Suite #:	City/state/zip:	
Recipient ID#:	DOB:	Phone:	Fax:		

CLINICAL INFORMATION

Medication requested: (*NOTE: For Entresto, refer to Entresto fax form; for Tekturma and Tekturma HCT, refer to Aliskiren Agents fax form.)

Angiotensin Converting Enzyme Inhibitors (ACE inhibitors)			Angiotensin Receptor Blockers (ARBs)		
<input type="checkbox"/> Accupril	<input type="checkbox"/> Lotensin HCT	<input type="checkbox"/> Quinapril	<input type="checkbox"/> Atacand	<input type="checkbox"/> Cozaar	<input type="checkbox"/> Hyzaar
<input type="checkbox"/> Altace	<input type="checkbox"/> Mavik	<input type="checkbox"/> Quinapril HCTZ	<input type="checkbox"/> Atacand HCT	<input type="checkbox"/> Diovan	<input type="checkbox"/> Micardis
<input type="checkbox"/> Benazepril HCTZ	<input type="checkbox"/> Moexipril	<input type="checkbox"/> Trandolapril	<input type="checkbox"/> Avalide	<input type="checkbox"/> Diovan HCT	<input type="checkbox"/> Micardis HCT
<input type="checkbox"/> Captopril	<input type="checkbox"/> Moexipril HCTZ	<input type="checkbox"/> Vasotec	<input type="checkbox"/> Avapro	<input type="checkbox"/> Edarbi	<input type="checkbox"/> Telmisartan
<input type="checkbox"/> Epaned	<input type="checkbox"/> Perindopril	<input type="checkbox"/> Vaseretic	<input type="checkbox"/> Candesartan	<input type="checkbox"/> Edarbyclor	<input type="checkbox"/> Telmisartan HCTZ
<input type="checkbox"/> Fosinopril HCTZ	<input type="checkbox"/> Prinivil	<input type="checkbox"/> Zestril	<input type="checkbox"/> Candesartan HCTZ	<input type="checkbox"/> Eprosartan	
<input type="checkbox"/> Lotensin					

Strength:	Directions:	Quantity:	Refills:
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Diagnosis:	Dx code (required):
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1. Has the Recipient tried and failed any of the preferred Angiotensin Modulators? Check all that apply.

ACE Inhibitors	ARBs	
<input type="checkbox"/> Benazepril	<input type="checkbox"/> Lisinopril	<input type="checkbox"/> Yes – <u>submit all supporting documentation of drug regimen and therapeutic failure</u> <input type="checkbox"/> No
<input type="checkbox"/> Captopril HCTZ	<input type="checkbox"/> Lisinopril HCTZ	
<input type="checkbox"/> Enalapril	<input type="checkbox"/> Quinapril	
<input type="checkbox"/> Enalapril HCTZ	<input type="checkbox"/> Ramipril	
<input type="checkbox"/> Fosinopril		
<input type="checkbox"/> Benicar	<input type="checkbox"/> Losartan	
<input type="checkbox"/> Benicar HCT	<input type="checkbox"/> Losartan HCTZ	
<input type="checkbox"/> Irbesartan	<input type="checkbox"/> Valsartan	
<input type="checkbox"/> Irbesartan HCTZ	<input type="checkbox"/> Valsartan HCTZ	

2. Does the Recipient have any contraindications or intolerances to any of the preferred agents listed in question (1)?

Yes – submit all supporting documentation of medication name(s) and associated intolerances / contraindications
 No

3. Is the Recipient currently taking any other ACE inhibitor or ARB (either alone or in combination)?

Yes – submit clinical documentation supporting the concomitant use of both medications or treatment plan to taper/discontinue one of the agents
 No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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