CarePlus HEALTH PLANS

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Entresto (sacubitril-valsartan) 49

Phone: 1-866-315-7587 Fax to: 1-800-310-9071

CarePlus manages the pharmacy drug benefit for your patient. Certain requests for prior authorization require additional information from the prescriber. Please provide the following information and fax this form to the number listed above. Information left blank or illegible may delay the review process.

Patient name:	**Prescriber name:**	
Member/subscriber number:	Fax:	Phone:
Patient date of birth:	Office contact:	
Group number:	NPI:	Tax ID:
Address:	Address:	
City, state ZIP:	City, state ZIP:	
	Specialty/facility name (if applicable):	

Drug name:	☐ Expedited/exigent/urgent
Directions/SIG:	By checking this box, I certify an expedited/exigent/urgent review is required. The member has a health condition that may seriously jeopardize his/her life or ability to regain maximum function. **(Please include explanation of exigency in the space below.)**
Quantity:	

Is this a proactive request for a new plan year? Yes____ No____ If yes, please provide plan year:_____

(Please note: All reviews will be processed with generic equivalents for brand drugs whenever possible.)

Please attach pertinent medical history or information for this patient that may support approval and sign this form.

Q1. Please provide diagnosis: *

Q2. Please provide ICD Diagnostic Codes:

Q3. Is the request for a reauthorization?

☐ Yes ☐ No

Q4. Does the patient have a diagnosis of NYHA Class II, III, or IV systolic heart failure? *

☐ Yes ☐ No

Q5. Will the patient continue to receive benefit from Entresto (sacubitril-valsartan)? *

☐ Yes ☐ No

Q6. Have the following safety issues been considered prior to prescribing Entresto? (Please mark all that apply) *

☐ Patients with prior history of angioedema (regardless of cause) may be at increased risk of angioedema with Entresto

☐ Use of Entresto is specifically contraindicated in patients with a history of angioedema related to previous

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Patient Name:	**Prescriber Name:**

angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy

☐ None of the above

Q7. If "None of the above" is checked, please explain:

Q8. Does the patient have diabetes? *

☐ Yes ☐ No

Q9. Will Entresto be used in combination with aliskiren? *

☐ Yes ☐ No

Q10. Is the patient currently experiencing symptomatic heart failure (i.e. diagnosis of NYHA Class II, III, or IV systolic heart failure)? *

☐ Yes ☐ No

Q11. Does the patient have left ventricular ejection fraction less than or equal to 40%? *

☐ Yes ☐ No

Q12. Was Entresto prescribed by or in consultation with a cardiologist or a provider with expertise in cardiac care?

☐ Yes ☐ No

Prescriber signature _____ Date _____

