carolina complete health

Entresto PA Request Form

Beneficiary Information

1. Beneficiary Last Name:_____2. First Name:_____

3. Beneficiary ID #:_____4. Beneficiary Date of Birth:_____5. Recipient Gender:_____

Prescriber Information

6. Prescribing Provider NPI#:_____

7. Requester Contact Information - Name:_____Phone #:_____Ext:_____

Drug Information

8. Med requested: **ENTRESTO** 9a. Strength_____9b. Quantity per 30 days_____9c. Duration_____

10. Does the beneficiary have a diagnosis of chronic heart failure (NYHA class II-IV) with a left ventricular ejection fraction (EF) less than or equal to 40%? **YES**___**NO**_____List ejection fraction_____

11a. Is Entresto being prescribed in conjunction with a beta blocker (e.g. metoprolol succinate, carvedilol) and/or Corlanor (ivabradine) for heart failure treatment? **YES**____**NO**_____

11b. Does the beneficiary have a contraindication to treatment with a beta blocker?

YES____**NO**_____

List the beta blocker prescribed or reason beta blocker will not be prescribed.

_____

_____

12. Does the beneficiary have a history of angioedema related to therapy with an ACE inhibitor or ARB?
YES____**NO**_____

13a. Is the beneficiary currently taking an ACE inhibitor or ARB? **YES**___**NO**_____

13b. If the beneficiary is currently taking an ACE inhibitor or ARB, will Entresto replace that current therapy? **YES**____**NO**____**N/A**_____

14a. Does the beneficiary have diabetes? **YES**____**NO**_____

14b. If the beneficiary has diabetes, is the beneficiary taking a medication containing aliskiren (e.g. Tekturna or Tekturna HCT)? **YES**____**NO**_____**N/A** _____

For reauthorization, please answer question 15

15. Is documentation attached to this request that indicates the beneficiary is receiving clinical benefit from Entresto such as stabilization of symptoms, improvement or stability of EF, or a reduction in hospitalizations?_**YES**_____**NO**__**N/A** _____

Signature of Prescriber:_____Date: _____

(Prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: (877) 386-4695 Pharmacy PA Call Center: (833) 585-4309