carolina complete health™

Pharmacy Prior Approval Request for Entresto

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: ____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. ____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days:_____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

1. 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: _____
2. Does the beneficiary have a history of angioedema related to therapy with an ACE inhibitor or ARB? ☐ **Yes** ☐ **No**

3a. Is the beneficiary currently taking an ACE inhibitor or ARB? ☐ **Yes** ☐ **No**

3b. If the beneficiary is currently taking an ACE inhibitor or ARB, will Entresto replace that current therapy? ☐ **Yes** ☐ **No**

4a. Does the beneficiary have diabetes? ☐ **Yes** ☐ **No**

4b. If the beneficiary has diabetes, is the beneficiary taking a medication containing aliskiren (e.g. Tekturna or Tekturna HCT)? ☐ **Yes** ☐ **No**

For reauthorization, please answer questions 1-5

5. Is documentation attached to this request that indicates the beneficiary is receiving clinical benefit from Entresto such as stabilization of symptoms, improvement? ☐ **Yes** ☐ **No**

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: (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309

https://www.covermymeds.com/main/prior-authorization-forms/

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