pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

ANGIOTENSIN MODULATORS PRIOR AUTHORIZATION FORM

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	
☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
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 Tekturna and Tekturna HCT, refer to Aliskiren Agents fax form.)*

Angiotensin Converting Enzyme Inhibitors (ACE inhibitors)			Angiotensin Receptor Blockers (ARBs)		
☐Accupril	☐Lotensin	☐Qbrelis	☐Atacand	☐candesartan HCTZ	☐Hyzaar
☐Accuretic	☐Lotensin HCT	☐quinapril HCTZ	☐Atacand HCT	☐Cozaar	☐Micardis
☐Altace	☐Mavik	☐trandolapril	☐Avalide	☐Diovan	☐Micardis HCT
☐benazepril HCTZ	☐moexipril	☐Vaseretic	☐Avapro	☐Diovan HCT	☐olmesartan
☐captopril	☐moexipril HCTZ	☐Vasotec	☐Benicar	☐Edarbi	☐olmesartan HCTZ
☐Epaned	☐perindopril	☐Zestoretic	☐Benicar HCT	☐Edarbyclor	☐telmisartan
☐fosinopril HCTZ	☐Prinivil	☐Zestril	☐candesartan	☐eprosartan	☐telmisartan HCTZ

Strength:	Directions:	Quantity:	Refills:
Diagnosis:		Dx code (required):	

1. Has the Recipient tried and failed any of the preferred Angiotensin Modulators? Check all that apply.

ACE Inhibitors		ARBs	
☐benazepril	☐lisinopril	☐irbesartan	☐losartan HCTZ
☐captopril HCTZ	☐lisinopril HCTZ	☐irbesartan HCTZ	☐valsartan
☐enalapril	☐quinapril	☐losartan	☐valsartan HCTZ
☐enalapril HCTZ	☐ramipril		
☐fosinopril			

☐Yes – *Submit all supporting documentation of drug regimen and therapeutic failure.*
☐No

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**: