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

ENTRESTO (sacubitril/valsartan) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Angiotensin Modulators (including Entresto)** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization.

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#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested: ☐Entresto tablet ☐Entresto _____	Strength:	
Directions:	Quantity:	Refills:
Diagnosis (*submit documentation*):	Dx code (*required*):	

Complete the following questions for ALL requests.

1. Is Entresto being prescribed by, or in consultation with, a cardiologist?	☐Yes ☐No	*Submit documentation of consultation, if applicable.*
2. Does the beneficiary have diabetes?	☐Yes ☐No	*Submit list of beneficiary's medical conditions.*
3. Will the beneficiary be taking any of the following medications in addition to Entresto? ☐an ACE inhibitor ☐an angiotensin II receptor blocker (ARB) ☐aliskiren (Tekturna)	☐Yes ☐No	*Submit a current complete list of beneficiary's medications.*
4. Does the beneficiary have recent results of liver function tests (LFTs)?	☐Yes ☐No	*Submit documentation.*

Complete the following questions for INITIAL requests only.

1. Does the beneficiary have a diagnosis of NYHA Functional Class II, III, or IV chronic heart failure and reduced ejection fraction?	☐Yes – *Submit documentation.* ☐No – *Submit medical literature supporting the use of Entresto for the beneficiary's diagnosis.*	
2. Is the beneficiary currently taking optimally tolerated doses for the treatment of heart failure of all of, or have a history of contraindication or intolerance to, the following types of medications? Check all that apply. **Beta-blockers** ☐bisoprolol ☐carvedilol ☐metoprolol succinate ER/XL ☐other: _____ **Mineralocorticoid receptor blockers** ☐eplerenone ☐spironolactone ☐other: _____ **Diuretics** ☐bumetanide ☐furosemide ☐HCTZ ☐other: _____	☐Yes ☐No	*Submit a current complete list of beneficiary's medications.*
3. Does the beneficiary have a history of tolerability of an ACE inhibitor or ARB? List ACE inhibitor(s)/ARB(s) tried: _____	☐Yes ☐No	*Submit documentation.*
4. Does the beneficiary have a history of angioedema associated with an ACE inhibitor or ARB?	☐Yes ☐No	*Submit documentation.*

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

Prescriber Signature:	**Date**: