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 MODULATOR COMBINATIONS PRIOR AUTHORIZATION FORM

- To review the prior authorization guidelines for Angiotensin Modulator Combination agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Angiotensin Modulator Combinations** (accessible at: http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm).
- These agents are also subject to quantity limits. If the requested quantity exceeds the limit, please submit supporting chart documentation (refer to **Quantity Limits / Daily Dose Limits** at: http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/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

Non-preferred medication requested*:
*(*NOTE: For Entresto, refer to Entresto fax form; for Tekturna and Tekturna HCT refer to Aliskiren Agents fax form.)*

☐Azor tablet
☐Byvalson tablet
☐Exforge tablet
☐Exforge HCT tablet
☐Lotrel capsule
☐olmesartan/amlodipine/HCTZ tablet
☐Prestalia tablet
☐Tarka tablet
☐telmisartan/amlodipine tablet
☐trandolapril/verapamil tablet
☐Tribenzor tablet
☐Twynsta tablet

Strength:	Directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	

1. Has the Recipient tried and failed any of the preferred Angiotensin Modulator Combination agents? *Check all that apply.*
   ☐amlodipine/benazepril capsule
   ☐amlodipine/olmesartan tablet
   ☐amlodipine/valsartan tablet
   ☐amlodipine/valsartan/HCTZ tablet

   ☐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 and contraindications.*
   ☐No

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

Prescriber Signature:	**Date**: