

## ANGIOTENSIN MODULATOR COMBINATIONS PRIOR AUTHORIZATION FORM

- Please submit **all** requested documentation with this form. Incomplete documentation may delay the processing of this request.
- 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		
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request: _____	Prescriber name: _____		
<input type="checkbox"/> Renewal request	PA#: _____				
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

<b>Non-preferred medication requested*:</b> (*NOTE: For Entresto, refer to Entresto fax form; for Tekturma and Tekturma HCT refer to Aliskiren Agents fax form.)			
<input type="checkbox"/> amlodipine/valsartan tablet	<input type="checkbox"/> telmisartan/amlodipine tablet	<input type="checkbox"/> amlodipine/valsartan/HCTZ tablet	<input type="checkbox"/> trandolapril/verapamil tablet
<input type="checkbox"/> Lotrel capsule	<input type="checkbox"/> Tribenzor tablet	<input type="checkbox"/> Prestalia tablet	<input type="checkbox"/> Twynsta tablet
<input type="checkbox"/> Tarka tablet			
Strength: _____	Directions: _____	Quantity: _____	Refills: _____
Diagnosis ( <u>submit documentation</u> ): _____		DX code ( <u>required</u> ): _____	
1. Has the Recipient tried and failed any of the preferred Angiotensin Modulator Combination agents? <i>Check all that apply.</i>		<input type="checkbox"/> Yes – <u>submit all supporting documentation of drug regimen and therapeutic failure</u> <input type="checkbox"/> No	
<input type="checkbox"/> amlodipine/benazepril capsule	<input type="checkbox"/> Exforge tablet		
<input type="checkbox"/> Azor tablet	<input type="checkbox"/> Exforge HCT tablet	<input type="checkbox"/> Yes – <u>submit all supporting documentation of medication name(s) and associated intolerances and contraindications</u> <input type="checkbox"/> No	
2. Does the Recipient have any contraindications or intolerances to any of the preferred agents listed in question (1)?			

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

Prescriber Signature: _____	Date: _____
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