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Entresto (sacubitril/valsartan) Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004 or Provider Help Desk at 1-800-454-3730.

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
Entresto (sacubitril/valsartan)	_____	_____	Specify: _____
7. Diagnosis: _____			

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization is required for valsartan/sacubitril (Entresto). Requests above the manufacturer recommended dosing will not be considered. Payment will be considered for patients when all of the following criteria are met:

1) Patient is 18 years of age or older.
2) Patient has a diagnosis of New York Heart Association Functional Class ll, lll, or lV heart failure.
3) Patient has a left ventricular ejection fraction (LVEF) ≤ 40 percent.
4) Patient is currently tolerating treatment with an ACE inhibitor or angiotensin II receptor blocker (ARB) at a therapeutic dose, where replacement with valsartan/sacubitril is recommended to further reduce morbidity and mortality.
5) Is to be administered in conjunction with other heart failure therapies, in place of an ACE inhibitor or other ARB (list medications patient is currently taking for the treatment of heart failure).
6) Will not be used in combination with an ACE inhibitor or ARB.
7) Will not be used in combination with aliskiren (Tekturna) in diabetic patients.
8) Patient does not have a history of angioedema associated with the use of ACE inhibitor or ARB therapy.

9) Patient is not pregnant.
10) Patient does not have severe hepatic impairment (Child Pugh Class C).
11) Prescriber is a cardiologist or has consulted with a cardiologist (telephone consultation is acceptable).

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Trial information

☐ Yes ☐ No Is patient currently tolerating treatment with an ACE inhibitor or ARB at a therapeutic dose? If yes, provide drug name and dose: _____
Therapy start date: _____ Medical or contraindication reason to override ACE inhibitor/ARB trial requirements: _____

☐ Yes ☐ No Will Entresto be used in combination with ACE inhibitor or ARB?

☐ Yes ☐ No Does the patient have a history of angioedema associated with ACE inhibitor or ARB therapy? Provide heart failure therapies to be used in conjunction with Entresto: _____

☐ Yes ☐ No If patient is diabetic, will Entresto be used in combination with aliskiren (Tekturna)? Provide patient's LVEF: _____ Date: obtained: _____Results: _____

☐ Yes ☐ No If female of child-bearing years, confirmed negative serum pregnancy test? If yes, name of prescriber: _____ Date of pregnancy test: _____

☐ Yes ☐ No Does patient have severe hepatic impairment (Child Pugh Class C)? Is prescriber a cardiologist? If no, note consultation with cardiologist:
Consultation date: _____ Physician name and phone: _____

Attach lab results and other documentation as necessary.

9. Physician signature

_____ _____
Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.
Note: Payment is subject to member eligibility. Authorization does not guarantee payment.