AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Entresto

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: **Entresto** 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days

Clinical Information

1. Does the beneficiary have a diagnosis of chronic heart failure (NYHA class II-IV) with a left ventricular ejection fraction (EF) less than or equal to 40%? Yes___ No___ List ejection fraction: _____
2. Does the beneficiary have a history of angioedema related to the therapy with an ACE inhibitor or ARB? Yes___ No___
3. Is the beneficiary currently taking an ACE inhibitor or ARB? Yes___ No___
   3a. If the beneficiary is currently taking an ACE inhibitor or ARB, will Entresto replace that current therapy? Yes___ No___
4. Does the beneficiary have diabetes? Yes___ No___
   4a. If the beneficiary has diabetes, is the beneficiary taking a medication containing aliskiren (e.g. Tekturna or Tekturna HCT)? Yes___ No___

For reauthorization, please answer questions 1-5

5. Is documentation attached to this request that indicates the beneficiary is receiving clinical benefit from Entresto such as stabilization of symptoms, improvement? Yes___ No___

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406