

**PRIOR AUTHORIZATION REQUEST FORM**

**Medicare Part D Entresto  
(sacubitril/valsartan)**

**Phone: 800-728-7947 Fax back to: 866-880-4532**

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note, any information left blank or illegible may delay the review process.

<b>Patient Name:</b>	<b>Prescriber Name: Supervising Physician:</b>	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

**Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.**

Q1. For what indication is this drug being prescribed (pick one)? <input type="checkbox"/> Stable Congestive Heart Failure (CHF) NYHA Class I <input type="checkbox"/> Stable Congestive Heart Failure (CHF) NYHA Class II <input type="checkbox"/> Stable Congestive Heart Failure (CHF) NYHA Class III <input type="checkbox"/> Stable Congestive Heart Failure (CHF) NYHA Class IV <input type="checkbox"/> Acute Decompensated Congestive Heart Failure (CHF) <input type="checkbox"/> Other
Q2. Please provide ICD code(s) for diagnosis.
Q3. Does patient have a history of ACE-I or ARB-related angioedema? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q4. Will Entresto be used in combination with Aliskiren, an ACE-I, or an ARB?

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Yes  No

Q5. Additional Comments

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

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