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.

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
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)?

- ☐ Stable Congestive Heart Failure (CHF) NYHA Class I
- ☐ Stable Congestive Heart Failure (CHF) NYHA Class II
- ☐ Stable Congestive Heart Failure (CHF) NYHA Class III
- ☐ Stable Congestive Heart Failure (CHF) NYHA Class IV
- ☐ Acute Decompensated Congestive Heart Failure (CHF)
- ☐ Other

Q2. Please provide ICD code(s) for diagnosis.

Q3. Does patient have a history of ACE-I or ARB-related angioedema?

☐ Yes ☐ No

Q4. Will Entresto be used in combination with Aliskiren, an ACE-I, or an ARB?

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Patient Name:	**Prescriber Name:** **Supervising Physician:**

☐ 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