



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

ARB Step Therapy

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:	
Member/Subscriber Number:	Supervising Physician:	
Date of Birth:	Fax:	Phone:
Group Number:	Office Contact:	
Address:	NPI:	State Lic ID:
City, State ZIP:	Address:	
Primary Phone:	City, State ZIP:	
	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. Please indicate drug requested. <input type="checkbox"/> Edarbi <input type="checkbox"/> Edarbyclor <input type="checkbox"/> Teveten HCT
Q2. Is the patient currently on the requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q3. Has the patient tried and failed any of the following drugs? <input type="checkbox"/> amlodipine/valsartan or amlodipine/valsartan/hctz <input type="checkbox"/> candesartan or candesartan/HCTZ <input type="checkbox"/> irbesartan or irbesartan/HCTZ <input type="checkbox"/> losartan or losartan/HCTZ <input type="checkbox"/> olmesartan or olmesartan/HCTZ <input type="checkbox"/> valsartan or valsartan/HCTZ <input type="checkbox"/> telmisartan <input type="checkbox"/> other (please specify) <input type="checkbox"/> None of the above
Q4. If applicable, please provide a written statement with supporting documentation as to why the patient is unable to take the above drug(s).



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Patient Name:	Prescriber Name: Supervising Physician:
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Q5. Additional Comments

Prescriber Signature	Date
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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

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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