PRIOR AUTHORIZATION FORM
Angiotensin Receptor Blockers (ARBs)

DATE OF REQUEST: ______________

MEMBER INFORMATION

NAME ________________________________

ID # ________________________________

BIRTHDATE ______________

☑ PLEASE NOTE: By signing this form, you are attesting to the accuracy of the information provided, and that medical record documentation is available if requested.

PROVIDER INFORMATION

NAME ________________________________

NPI # ________________________________

ADDRESS ________________________________

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PHONE #______________FAX #______________

CONTACT NAME ________________________________

PROVIDER SIGNATURE ________________________________

Drug Requested: ________________________ **Dose/frequency:** ________________________

Diagnosis________________________ **ICD-9 code** ________________________

Please check one ☐ **Initial Request** ☐ **Extension Request**

For **Avapro/Avalide, Diovan/Diovan HCT, Azor, Exforge, Twynsta or losartan/losartan w HCTZ**

Has the patient experienced intolerance (i.e., sensitivity, drug allergy, or adverse effect) or failure to treatment with an ACE Inhibitor? ☐ NO ☐ YES

If yes, which ACEI:________________________________

For **Atacand/HCT, Benicar/HCT, Cozaar (brand), Hyzaar (brand), Micardis/HCT or Teveten/HCT:**

Has the patient experienced intolerance (i.e., sensitivity, drug allergy, or adverse effect) or failure to treatment with ALL formulary/select ARBs listed below? ☐ NO ☐ YES

If yes, please provide details of history of ARB use (please circle):

	Experienced Intolerance		Treatment Failure		Samples Provided	
losartan/losartan HCTZ	YES	NO	YES	NO	YES	NO
Avapro/Avalide®	YES	NO	YES	NO	YES	NO
Diovan/Diovan HCT®	YES	NO	YES	NO	YES	NO

☑ **PLEASE NOTE:** ALL CHART NOTES/LAB REPORTS IN REFERENCE TO THIS REQUEST MUST BE RECEIVED BEFORE A REVIEW CAN BEGIN. *REQUESTS SUBMITTED WITHOUT THIS DOCUMENTATION MAY BE DENIED.*

*Refer to the MVP Formulary at **www.mvphealthcare.com** for those drugs that require prior authorization or are subject to quantity limits or step therapy.*

FAX THIS REQUEST TO:

Commercial **1-800-376-6373**
(HMO, EPO/PPO, Option Child, Healthy NY, Personal Plan, CompCare, ASO)

Medicare Part D **1-800-401-0915**
(Preferred Gold, GoldAnywhere, GoldValue, USA Care, MVP RxCare)

Effective July 2010