

Entresto Prior Authorization Form

Member Information		
1. Member last name:	2. Member first name:	
3. Member ID #:	4. Member date of birth:	5. Member gender:
Prescriber Information		
6. Prescribing provider NPI#:		
7. Requester contact information		
Name:		
Phone:	Ext:	
Drug Information		
8. Drug name:	9. Strength:	
10. Quantity per 30 days:		
11. Length of therapy (in days): <input type="checkbox"/> up to 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 120 days <input type="checkbox"/> 180 days <input type="checkbox"/> 365 days		
Clinical Information		
1. Does the member have a diagnosis of chronic heart failure (NYHA class II-IV) with a left ventricular ejection fraction (EF) less than or equal to 40%? <input type="checkbox"/> Yes <input type="checkbox"/> No		
List ejection fraction:		
2. Does the member have a history of angioedema related to therapy with an ACE inhibitor or ARB? <input type="checkbox"/> Yes <input type="checkbox"/> No		
3a. Is the member currently taking an ACE inhibitor or ARB? <input type="checkbox"/> Yes <input type="checkbox"/> No		
3b. If the member is currently taking an ACE inhibitor or ARB, will Entresto replace that current therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
4a. Does the member have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No		
4b. If the member has diabetes, is the member taking a medication containing aliskiren (e.g. Tekturna or Tekturna HCT)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
For reauthorization, please answer questions 1-5		

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5. Is documentation attached to this request that indicates the member 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 **844-376-2318**

Healthy Blue and Healthy Blue Care Together Pharmacy PA Call Center: **844-594-5072** (Healthy Blue Provider Services) or **833-777-3698** (Healthy Blue Care Together Provider Services)