UnitedHealthcare Community Plan

Entresto
PRIOR AUTHORIZATION REQUEST FORM

Please complete this entire form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form contains multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication □ New or □ Continuation of Therapy? If continuation, list start date: ________________
Is this patient currently hospitalized? □ Yes □ No

Section B - Physician Information

First Name:		Last Name: M.D./D.O.		
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Dispense as Written: □ **Yes** □ **No**	
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**
Is this member pregnant? □ **Yes** □ **No**	**If yes, what is this member's due date?** ________________

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information about this case, if any:

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Clinical and Drug Specific Information
(*must* be completed in its entirety)

New Requests:

- Is the medication a continuation of therapy initiated during an inpatient stay? □ Yes □ No

- Does the patient have a diagnosis of heart failure (with or without hypertension)? □ Yes □ No

- What is the patient's ejection fraction percentage? List: ___________%

- Does the Patient have heart failure classified as any of the following? (check which applies) □ Yes □ No
□ New York Heart association Class II □ New York Heart association Class III □ New York Heart association Class IV

- Is the patient on a stabilized dose and receiving concomitant therapy with any of the following? □ Yes □ No
(if yes, check which applies)
□ Bisoprolol □ Carvedilol □ Metoprolol Succinate

- Does the patient have a contraindication to beta-blocker therapy? □ Yes □ No

- Has the patient been hospitalized for heart failure in the past 12 months? □ Yes □ No

- What is the most recent B-type natriuretic peptide level? __________pg/mL
(while on therapeutic, or maximally tolerated, doses of evidence-based recommended medications for heart failure)

- Does the patient have a history of angioedema? □ Yes □ No

- Will the patient be discontinuing any use of concomitant ACE Inhibitor or ARB before initiating treatment with Entresto? □ Yes □ No (ACE inhibitors must be d/c at least 36 hours prior to initiation of Entresto)

- Will the patient be concomitantly on aliskiren therapy? □ Yes □ No

- Is the medication being prescribed by, or in consultation with, a cardiologist? □ Yes □ No

Continuation of Therapy:

- Has the dose of Entresto been titrated to 97mg/103mg twice daily, or to a maximum dose tolerated? □ Yes □ No

- Has the patient had positive clinical response to therapy? □ Yes □ No
List response: ____
____

Physician Signature: ______________________________ **Date:** ______________

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