OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Angiotensin Receptor Blockers Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Cardiovascular risk reduction in patients who are unable to take angiotensin converting enzyme (ACE) inhibitors (**Micardis** only)
- ❑ Heart failure (New York Heart Association [NYHA] class II-IV) [**Atacand** and **Diovan** only]
- ❑ Hypertension (HTN)
- ❑ Nephropathy in type 2 diabetic patient (**Avapro** and **Cozaar** only)
- ❑ Reduction in the risk of stroke in patient with hypertension and left ventricular hypertrophy (**Cozaar** and **Hyzaar** only)
- ❑ Reduction of cardiovascular mortality in clinically stable patients with left ventricular failure or dysfunction following myocardial infarction (**Diovan** only)
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Select the medications the patient has a failure, contraindication, or intolerance to:

- ❑ Amlodipine-benazepril
- ❑ Amlodipine-olmesartan
- ❑ Benazepril
- ❑ Benazepril-hydrochlorothiazide (HCTZ)
- ❑ Candesartan
- ❑ Candesartan-HCTZ
- ❑ Captopril
- ❑ Captopril-HCTZ
- ❑ Enalapril
- ❑ Enalapril-HCTZ
- ❑ Eprosartan
- ❑ Fosinopril
- ❑ Fosinopril-HCTZ
- ❑ Irbesartan
- ❑ Irbesartan-HCTZ
- ❑ Lisinopril
- ❑ Lisinopril-HCTZ
- ❑ Losartan
- ❑ Losartan-HCTZ
- ❑ Moexipril
- ❑ Moexipril-HCTZ
- ❑ Olmesartan
- ❑ Olmesartan-HCTZ
- ❑ Olmesartan-amlodipine-HCTZ
- ❑ Perindopril
- ❑ Quinapril
- ❑ Quinapril-HCTZ
- ❑ Ramipril
- ❑ Telmisartan
- ❑ Telmisartan-HCTZ
- ❑ Trandolapril
- ❑ Trandolapril-verapamil extended-release (ER)
- ❑ Valsartan
- ❑ Valsartan-HCTZ
- ❑ Other angiotensin-converting enzyme inhibitor (ACEI). Please specify: _____
- ❑ Other ACEI/HCTZ combination. Please specify: _____
- ❑ Other ACEI/Calcium channel blocker (CCB) combination. Please specify: _____

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

Angiotensin Receptor Blockers Prior Authorization Request Form (Page 2 of 2)

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.