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

Entresto® 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:

❑ Heart failure (with or without hypertension)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Continuation of therapy:

Is the requested medication a continuation of therapy initiated during an inpatient stay? ❑ **Yes** ❑ **No**

Prescriber's specialty:

Was the requested medication prescribed by or in consultation with a cardiologist? ❑ **Yes** ❑ **No**

Clinical information:

Does the patient have an ejection fraction that is less than or equal to 40 percent? ❑ **Yes** ❑ **No**

Is the patient's heart failure classified as one of the following: New York Heart Association Class II, III or IV? ❑ **Yes** ❑ **No**

Is the patient on a stabilized dose and receiving concomitant therapy with one of the following beta blockers: Bisoprolol, carvedilol, or metoprolol? ❑ **Yes** ❑ **No**

Does the patient have a contraindication or intolerance to beta-blocker therapy? ❑ **Yes** ❑ **No**

Does the patient have a history of angioedema? ❑ **Yes** ❑ **No**

Will the patient discontinue any use of concomitant angiotensin-converting enzyme (ACE) inhibitors or angiotensin-II receptor blockers (ARB) before initiating treatment with Entresto? ❑ **Yes** ❑ **No**

Please note: ACE inhibitors must be discontinued at least 36 hours prior to initiation of Entresto

Is the patient receiving concomitant aliskiren (Tekturna) therapy? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following:

Has the dose of Entresto been titrated to a dose of 97mg/103mg twice daily, or to a maximum dose as tolerated by the patient? ❑ **Yes** ❑ **No**

Is there documentation of positive clinical response to therapy? ❑ **Yes** ❑ **No**

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: _____

Entresto® 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.