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

Atacand® (candesartan), Atacand HCT® (candesartan-HCTZ), eprosartan Prior Authorization Request Form

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 [**Atacand (candesartan)** only]
- ❑ Hypertension
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

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

- ❑ Amlodipine-olmesartan
- ❑ Amlodipine-olmesartan-hydrochlorothiazide (HCTZ)
- ❑ Amlodipine-valsartan
- ❑ Amlodipine-valsartan-HCTZ
- ❑ Candesartan
- ❑ Candesartan-HCTZ
- ❑ Edarbi
- ❑ Edarbyclor
- ❑ Eprosartan
- ❑ Irbesartan
- ❑ Irbesartan-HCTZ
- ❑ Losartan
- ❑ Losartan-HCTZ
- ❑ Olmesartan
- ❑ Olmesartan-HCTZ
- ❑ Telmisartan
- ❑ Telmisartan-amlodipine
- ❑ Telmisartan-HCTZ
- ❑ Valsartan
- ❑ Valsartan-HCTZ
- ❑ Generic angiotensin converting enzyme (ACE) inhibitor (e.g., benazepril, captopril, enalapril, fosinopril, lisinopril, moexipril, perindopril, quinapril, ramipril, trandolapril)
- ❑ Generic ACE inhibitor combination (e.g., amlodipine-benazepril, benazepril-HCTZ, captopril-HCTZ, enalapril-HCTZ, fosinopril-HCTZ, lisinopril-HCTZ, moexipril-HCTZ, quinapril-HCTZ, trandolapril-verapamil extended-release [ER])

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
- ❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____
- ❑ Other: _____

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.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
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.