



Please complete ALL information below and fax your request to 1-888-671-5285

Tekturna[®] and Tekturna HCT[®] Coverage Determination Request Form

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

| Member Information (required) | | | Provider Information (required) | | |
|-------------------------------|--------|------|---------------------------------|-----------------|------|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | Specialty: | |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | Office Contact: | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |

| Medication Information (required) | | |
|---|---------------------|--------------|
| Medication Name: Select one of the following: <input type="checkbox"/> Request is for GENERIC <input type="checkbox"/> Request is for BRAND (unable to take the generic) | Strength: | Dosage Form: |
| <input type="checkbox"/> Check if request is for continuation of therapy | Directions for Use: | |

| Clinical Information (required) |
|--|
| Select the Type(s) of Coverage Determination Requested: <input type="checkbox"/> Step Therapy - Request is for an exception to try another drug before the requested drug being prescribed. <input type="checkbox"/> Quantity Limit - Request is for an exception to the plan's quantity limit. Quantity per DAY requested? _____ |
| Select the diagnosis below: <input type="checkbox"/> Hypertension <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____ |
| Medication history: Does the patient have a history of trial and failure, or intolerance to ONE generic angiotensin converting enzyme (ACE) inhibitor (benazepril, benazepril/hydrochlorothiazide (HCTZ), captopril, captopril/HCTZ, enalapril, enalapril/HCTZ, fosinopril, fosinopril/HCTZ, lisinopril, lisinopril/HCTZ, moexipril, perindopril, quinapril, quinapril/HCTZ, ramipril, trandolapril, trandolapril/verapamil)? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please specify: _____ Does the patient have a history of trial and failure, or intolerance to ONE generic angiotensin II receptor blocker (ARB) (candesartan, candesartan/HCTZ, eprosartan, irbesartan, irbesartan/HCTZ, losartan, losartan/HCTZ, olmesartan, olmesartan/amlodipine/HCTZ, olmesartan/amlodipine, olmesartan/HCTZ, telmisartan, telmisartan/HCTZ, telmisartan/amlodipine, valsartan, valsartan/amlodipine, valsartan/amlodipine/HCTZ, valsartan/HCTZ)? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please specify: _____ |
| Quantity limit requests: Is there a high risk of significant adverse clinical outcome with medication change or dosage change? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the requested quantity and dose within FDA approved maximum dosing limits or supported by peer-reviewed medical literature, accepted standards of medical practice and/or medical compendia? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please specify: _____ |

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.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of FutureScripts. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**
Office use only: Tekturna-TekturnaHCT_FSPartD_2019Jun-W