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

Angiotensin Receptor Blockers Prior Authorization Request Form

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

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Hypertension (HTN)

❑ 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
❑ Fosinopril
❑ Fosinopril-HCTZ
❑ Irbesartan
❑ Irbesartan-HCTZ
❑ Lisinopril
❑ Lisinopril-HCTZ
❑ Losartan
❑ Losartan-HCTZ
❑ Moexipril
❑ Moexipril-HCTZ
❑ Olmesartan
❑ Olmesartan-amlodipine-HCTZ
❑ Olmesartan-HCTZ
❑ Perindopril
❑ Quinapril
❑ Quinapril-HCTZ
❑ Ramipril
❑ Telmisartan
❑ Telmisartan-HCTZ
❑ Trandolapril
❑ Trandolapril-verapamil extended-release (ER)

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

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Please note: This request may be denied unless all required information is received.

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