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

Angiotensin Receptor Blockers (ARBs) & ARB Combinations Prior Authorization 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:		
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:

❑ Heart failure
❑ Hypertension
❑ Nephropathy in Type 2 Diabetic Patients
❑ Reduction of cardiovascular mortality in clinically stable patients with left ventricular failure or dysfunction following myocardial infarction (MI)
❑ Reduction of MI, stroke, or death from cardiovascular causes in patients at high risk for developing major cardiovascular events and are unable to take angiotensin converting enzyme (ACE) inhibitors
❑ Reduction of stroke risk in patients with hypertension and left ventricular hypertrophy
❑ Other diagnosis: ________________________________ ICD-10 Code(s): ________________________________

Medication history:

Select the medications the patient has had an inability to tolerate or has had an inadequate response to:

❑ Losartan
❑ Olmesartan
❑ Valsartan
❑ Other generic ARBs or combinations not listed above. (Please specify all agents):________________________________

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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?

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

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