



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Entresto

Phone: 215-991-4300

Fax back to: 866-240-3712

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Form with fields for Patient Name, HPP Member Number, Date of Birth, Address, City, State ZIP, Patient Primary Phone, Line of Business (Medicaid, CHIP), Prescriber Name, Fax, Phone, Office Contact, NPI, Promise ID, Prescriber PA PROMISe ID, Address, City, State ZIP, Specialty/facility name (if applicable).

Expedited/Urgent checkbox

Drug Name:

Strength:

Days Supply:

Number of Refills:

Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is the patient 18 years of age or older?

Yes checkbox

No checkbox

Q2. Is the prescriber a cardiologist or has the medication been prescribed in consultation with a cardiologist? Must attach documentation of consultation if applicable.

Yes checkbox

No checkbox

Q3. Does the patient have a diagnosis of New York Heart Association (NYHA) Class II or III heart failure (at least some limitation of physical activity, with ordinary physical activity resulting in symptoms of heart failure) and reduced ejection fraction (EF; <40%)? Must attach documentation.

Yes checkbox

No checkbox

Q4. Does the patient have a history of angioedema related to angiotensin-converting enzyme inhibitors (ACEIs) or angiotensin II receptor blockers (ARBs)?

Yes checkbox

No checkbox

Q5. Is the patient currently being treated with and tolerating ACEI or ARB therapy for at least 1 month?

Yes checkbox

No checkbox

Q6. Is the patient currently being treated with the following additional standard therapies for at least 1 month: I. Beta blocker (bisoprolol, carvedilol, or metoprolol succinate extended-release) titrated to a maximally tolerated dose (unless

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Prescriber Name:

intolerance to at least 1 or contraindication to all 3 agents), and II. Aldosterone antagonist (unless intolerance or contraindication to therapy such as estimated glomerular filtration rate [eGFR]<30 mL/min/1.73 m2, serum potassium >5.0 mEq/L, etc.)?

Yes checkbox

No checkbox

Q7. Requested Duration:

12 months checkbox

Q8. Additional Information:

Prescriber Signature

Date

Updated 2018