Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

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.

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

□ Expedited/Urgent

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 ☐ No

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 ☐ No

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 ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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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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 ☐ No

Q7. Requested Duration:

☐ 12 months

Q8. Additional Information:

Prescriber Signature

Date

Updated 2018