AmeriHealth

Prior Authorization Form

Oral antihypertensive agents

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug requested: ☐ **Diovan®** ☐ **Diovan HCT®,** ☐ **Benicar®** ☐ **Benicar HCT®,** ☐ **Cozaar®** ☐ **Hyzaar®,** ☐ **Azor** ☐ **Exforge** ☐ **Exforge HCT** ☐**Tekturna HCT** ☐ **Avapro®** ☐**Avalide®,** ☐ **Teveten®** ☐ **Teveten** ☐ **Micardis®** ☐ **Micardis HCT®,** ☐ **Atacand®** ☐ **Atacand HCT®** ☐ **Tekturna**

Date: _____ Patient ID#: _____ DOB:_____

Patient Name: _____ Provider NPI: _____

Prescribing Physician: _____ Office Contact: _____

Office Fax #: _____ Office Phone: _____

1. DIAGNOSIS FOR DRUG REQUESTED:

☐ Hypertension ☐ Type II Diabetes with renal insufficiency ☐ Other (specify)_____

2. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

☐ **N/A** If none or not applicable to diagnosis, indicate "N/A."

Drug Name	Date	Duration

3. PATIENT HISTORY:

a. Has the patient tried and failed an ACE containing product for a minimum of 30 days? ☐ Yes ☐ No

b. Has the patient tried and failed an ACE containing product in the past 6 months? ☐ Yes ☐ No

c. Does the patient have an intolerance or contraindication to an ACE containing product? ☐ Yes ☐ No

Please specify _____

_____

FOR THE FOLLOWING QUESTIONS (D, E, F, G) DOCUMENT THE DATES IN THE MEDICATION HISTORY SECTION

d. Has the patient tried and failed a Diovan containing product for a minimum of 30 days? ☐ Yes ☐ No ☐ N/A

e. Has the patient tried and failed a Benicar containing product for a minimum of 30 days? ☐ Yes ☐ No ☐ N/A

f. Has the patient tried an amlodipine containing product for a minimum of 30 days? ☐ Yes ☐ No ☐ N/A

g. Is the patient non-compliant? ☐ Yes ☐ No ☐ N/A

Tekturna/Tekturna HCT & Azor (Commercial Only):

h. Has the patient tried and failed or has a contraindication/intolerance/allergy to an ACE containing product? ☐ Yes ☐ No

i. Has the patient tried and failed or has a contraindication to a Diovan containing product? ☐ Yes ☐ No

j. Has the patient tried and failed or has a contraindication to a Benicar containing product? ☐ Yes ☐ No

k. Has the patient tried and failed or has a contraindication to an amlodipine containing product? ☐ Yes ☐ No

Please add any other supporting medical information that may be useful in the decision-making process:

_____

_____

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

Internal use only **Coverage effective date / /**

Document #_____ Processor Initials_____ Date_____

M F Rx coverage Y N STANDARD - SELECT LOB_____

Previous Auth Y N **Approved** **Reviewer Initials**_____ Date_____

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