



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 HCT® [] Micardis® [] Micardis HCT®, [] Atacand® [] Atacand HCT®
[] Tekturna [] Twynsta® [] Valturna®

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."

Table with 3 columns: Drug Name, Date, Duration. Includes blank lines for entry.

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 Diovan containing product for a minimum of 30 days? [] Yes [] No [] N/A
e. Has the patient tried and failed Benicar containing product for a minimum of 30 days? [] Yes [] No [] N/A
f. Has the patient tried 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, Valturna & Azor Only:

- h. Has the patient tried and failed or has a contraindication/intolerance/allergy to an ACE containing product? [] Yes [] No [] N/A
i. Has the patient tried and failed or has a contraindication to Diovan containing product? [] Yes [] No [] N/A
j. Has the patient tried and failed or has a contraindication to Benicar containing product? [] Yes [] No [] N/A
k. Has the patient tried and failed or has a contraindication to amlodipine containing product? [] Yes [] No [] N/A

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