FAX Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization
VALSARTAN/SACUBITRIL (ENTRESTO)
(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for valsartan/sacubitril (Entresto). Requests above the manufacturer recommended dosing will not be considered. Payment will be considered for patients when the following criteria are met:

1) **Patient is within the FDA labeled age for indication; and**
2) **Patient has a diagnosis of NYHA Functional Class II, III, or IV heart failure; and**
   a) **Patient has a left ventricular ejection fraction (LVEF) ≤40%; and**
   b) **Patient is currently tolerating treatment with an ACE inhibitor or angiotensin II receptor blocker (ARB) at a therapeutic dose, where replacement with valsartan/sacubitril is recommended to further reduce morbidity and mortality; and**
   c) **Is to be administered in conjunction with other heart failure therapies, in place of an ACE inhibitor or other ARB (list medications patient is currently taking for the treatment of heart failure); or**
3) **Pediatric patient has a diagnosis of symptomatic heart failure (NYHA/Ross Class II to IV) due to systemic left ventricular systolic dysfunction with documentation of a left ventricular ejection fraction ≤ 40%; and**
4) **Will not be used in combination with an ACE inhibitor or ARB; and**
5) **Will not be used in combination with aliskiren (Tekturna) in diabetic patients; and**
6) **Patient does not have a history of angioedema associated with the use of ACE inhibitor or ARB therapy; and**
7) **Patient is not pregnant; and**
8) **Patient does not have severe hepatic impairment (Child Pugh Class C).**

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred

☐ Entresto

Strength_____ **Dosage Instructions**_____ **Quantity**_____ **Days Supply**_____

Diagnosis:_____

iowa total care ia health link Hawki

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Will Entresto be used in combination with ACE inhibitor or ARB? ☐ Yes ☐ No

Does patient have a history of angioedema associated with ACE inhibitor or ARB therapy?

☐ Yes ☐ No

If patient is diabetic, will Entresto be used in combination with aliskiren (Tekturna)? ☐ Yes ☐ No

If female of child-bearing years, confirmed negative serum pregnancy test? ☐ Yes ☐ No

If yes, please list Prescriber:_____ Date of pregnancy test:_____

Does patient have severe hepatic impairment (Child Pugh Class C)? ☐ Yes ☐ No

Adult Heart Failure Patients Only:

Is patient currently tolerating treatment with an ACE inhibitor or ARB at a therapeutic dose? ☐ Yes ☐ No

If Yes, Provide: Drug Name & Dose: _____ Therapy Start Date: _____

Medical or contraindication reason to override ACE Inhibitor/ARB trial requirements:_____

_____

Provide heart failure therapies to be used in conjunction with Entresto:_____

_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*