

OPTIMA HEALTH COMMUNITY CARE

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-319-5003. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete forms will delay the authorization process.

Drug Requested: **Entresto® (sacubitril/valsartan) (Non-Preferred)** **MEDICAID**

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Quantity Limit: **2 per day**

CLINICAL INFORMATION: The following criteria **must** be met or authorization process will be delayed.

- Patient has diagnosis of chronic heart failure (NYHA Class II-IV), **AND**
- Must be ≥ 18 years, **AND**
- Left ventricular ejection fraction $\leq 40\%$

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria. ****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

*REVISED/UPDATED: 6/30/2017 9/2/2017