OPTIMA HEALTH PLAN

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 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.***

Drug Requested: **Entresto**® (sacubitril and valsartan)

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***: _____

CLINICAL CRITERIA**:** ***Boxes MUST be checked below to qualify or authorization process will be delayed. Chart documentation MUST be attached to this request.***

- ❑ Patient has tried and failed ace inhibitor therapy with LVEF remaining < 40%
- ❑ Patient has been diagnosed with Heart Failure (NYHA Class II-IV)
- ❑ Patient is currently receiving maximum pharmaceutical therapy for heart failure

*****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 #: _____

***Approved by Pharmacy and Therapeutics Committee**: 11/19/2015
REVISED/UPDATED: ~~12/22/2015~~; ~~12/16/2016~~; **8/12/2017**