

TRICARE Prior Authorization Request Form for  
**sacubitril-valsartan (generic Entresto)**



**JOHNS HOPKINS**  
 HEALTH PLANS

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**Fax completed form and  
 applicable progress notes to:  
 (410) 424-4037**

**USFHP Pharmacy Prior Authorization Form**

To be completed by requesting provider	
Drug Name: _____	Strength: _____
Dosage/Frequency (SIG): _____	Duration of Therapy: _____

**Questions?** Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical documentation must accompany form in order for a determination to be made.

Prior authorization does not expire.

**Step 1** Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID #: _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

**Step 2** Please complete the clinical assessment:

<p>1. The brand Entresto tablet is the preferred product over generic sacubitril/valsartan tablets and is covered at the lowest copayment, which is the generic formulary copayment for non-Active-Duty patients, and at no cost share for Active-Duty patients. (Although Entresto is a branded product, it will be covered at the generic formulary copayment or cost share).</p>	<p><input type="checkbox"/> Acknowledged                  Proceed to question 2</p>
<p>2. Please provide a patient-specific justification as to why the brand Entresto cannot be used in this patient.</p>	<p>_____                  Sign and date below</p>

**Step 3** I certify the above is true to the best of my knowledge. Please sign and date:

_____ Prescriber Signature	_____ Date
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[12 March 2025]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: