Prior Authorization Request Form for Sacubitril/valsartan (Entresto)

JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

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.

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:**

Question	Yes	No
1. Is the initial prescription written by or in consultation with a cardiologist?	☐ Yes Proceed to question 2	☐ No Coverage not approved
2. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question 3	☐ No Coverage not approved
3. Does the patient have a documented diagnosis of chronic heart failure (New York Heart Association class II-IV) with a left ventricular ejection fraction less than or equal to 35% with continued heart failure symptoms?	☐ Yes Proceed to question 4	☐ No Coverage not approved
4. Is the patient receiving concomitant treatment with a beta-blocker that has been shown to have a survival benefit in heart failure, at maximally tolerated doses? *Note: metoprolol succinate ER 200 mg QD; carvedilol 25 mg BID or 50 mg BID if greater than 85 kg; carvedilol ER 80 mg QD; bisoprolol 10 mg QD*	☐ Yes **Skip** to question 6	☐ No Proceed to question 5
5. Does the patient have a contraindication to a beta-blocker? *Note: hypersensitivity, cardiogenic shock or overt cardiac failure, second or third degree heart block, asthma, COPD*	☐ Yes Proceed to question 6	☐ No Coverage not approved
6. Has the patient been stable on any ACE inhibitor or preferred ARB that has shown to have benefit in heart failure (such as losartan, valsartan) for at least 4 weeks at maximally tolerated doses?	☐ Yes Proceed to question 7	☐ No Coverage not approved
7. Does the patient have a history of angioedema due to an ACE inhibitor or ARB?	☐ Yes Coverage not approved	☐ No Sign and date below

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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For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: