Prior Authorization Request Form for perindopril-amlodipine (Prestalia)

JOHNS HOPKINS MEDICINE
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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.

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 note:**

The PREFERRED renin angiotensin antihypertensive (RAA) agents to Prestalia are: generic ACE inhibitors (benazepril, captopril, enalapril, fosinopril, lisinopril, moexipril, perindopril, quinapril, ramipril, trandolapril), Cozaar (losartan), Hyzaar (losartan-HCTZ), Diovan (valsartan), Diovan HCT (valsartan-HCTZ), Exforge (valsartan-amlodipine), Exforge HCT (valsartan-amlodipine-HCTZ), Micardis (telmisartan), Micardis HCT (telmisartan-HCTZ), Avapro (irbesartan), Avalide (irbesartan + HCTZ), and Twynsta (telmisartan-amlodipine). **They are covered without prior authorization. You do NOT need to complete this form for coverage of the preferred RAA agents.**

Step 3 **Please complete the clinical assessment:**

1. Has the patient had a trial of one preferred renin angiotensin antihypertensive (RAA) agent and was unable to tolerate treatment due to adverse effects?	☐ Yes Sign and date below	☐ No Proceed to question 2
2. Has the patient had a trial of one preferred RAA agent and has had an inadequate response?	☐ Yes Sign and date below	☐ No Proceed to question 3
3. Does the patient have a contraindication to the preferred RAA agents that is not expected to occur with Prestalia?	☐ Yes Sign and date below	☐ No Coverage not approved

Step 4 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[14 February 2018]

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