



Request for Prior Authorization
VALSARTAN/SACUBITRIL (ENTRESTO)

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for valsartan/sacubitril (Entresto). Requests above the manufacturer recommended dosing will not be considered. Payment will be considered for patients when the following criteria are met:

- 1) Patient is 18 years of age or older; and
2) Patient has a diagnosis of NYHA Functional Class II, III, or IV heart failure; and
3) Patient has a left ventricular ejection fraction (LVEF) ≤40%; and
4) Patient has documentation of a previous trial and therapy failure or intolerance to an ACE inhibitor at maximally tolerated dose; and
5) Patient has documentation of a previous trial and therapy failure or intolerance to an angiotensin II receptor blocker (ARB); and
6) Is to be administered in conjunction with other heart failure therapies, in place of an ACE inhibitor or other ARB (list medications patient is currently taking for the treatment of heart failure); and
7) Will not be used in combination with an ACE inhibitor or ARB; and
8) Will not be used in combination with aliskiren (Tekturna) in diabetic patients; and
9) Patient does not have a history of angioedema associated with the use of ACE inhibitor or ARB therapy; and
10) Patient is not pregnant; and
11) Patient does not have severe hepatic impairment (Child Pugh Class C); and
12) Prescriber is a cardiologist or has consulted with a cardiologist (telephone consultation is acceptable).

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

If the criteria for coverage are met, initial authorization will be given for 3 months. Requests for continuation of therapy may be provided if prescriber documents adequate response to therapy.

Non-Preferred

Entresto

Strength Dosage Instructions Quantity Days Supply

Diagnosis:

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Trial Information:

ACE inhibitor trial: Dose: _____ Trial dates: _____

Failure reason: _____

ARB trial: Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Medical or contraindication reason to override ACE Inhibitor/ARB trial requirements: _____

Will Entresto be used in combination with ACE inhibitor or ARB? Yes No

Does patient have a history of angioedema associated with ACE inhibitor or ARB therapy? Yes No

Provide heart failure therapies to be used in conjunction with Entresto: _____

If patient is diabetic, will Entresto be used in combination with aliskiren (Tekturna)? Yes No

Provide patient's left ventricular ejection fraction: _____ Date obtained: _____

Results: _____

If female of child-bearing years, confirmed negative serum pregnancy test? Yes No

If yes, please list Prescriber: _____ Date of pregnancy test: _____

Does patient have severe hepatic impairment (Child Pugh Class C)? Yes No

Is Prescriber a cardiologist? Yes No If no, note consultation with cardiologist:

Consultation date: _____ Physician name & phone: _____

Renewal Requests: Provide documentation of adequate response to treatment:

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.