



Request for Prior Authorization
ANGIOTENSIN RECEPTOR BLOCKER BEFORE ACE INHIBITOR

(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.

Payment for Angiotensin Receptor Blockers (ARB) and Angiotensin Receptor Blocker Combinations will only be considered for cases in which there is a contraindication or therapy failure with at least one ACE-I or ACE-I Combination.

Preferred

- Amlodipine/Olmesartan
Amlodipine/Valsartan
Amlodipine/ Valsartan/HCTZ
Irbesartan
Irbesartan HCT
Losartan
Losartan HCT
Valsartan
Valsartan HCT

Non-Preferred

- Atacand
Atacand HCT
Avalide
Avapro
Azor
Benicar
Benicar HCT
Cozaar
Diovan
Diovan HCT
Edarbi
Edarbyclor
Eprosartan
Exforge
Exforge HCT
Hyzaar
Micardis
Micardis HCT
Olmesartan
Olmesartan/Amlodipine/HCTZ
Olmesartan/HCTZ
Telmisartan
Telmisartan/Amlodipine
Telmisartan HCT
Teveten
Teveten HCT
Tribenzor
Twynsta
Valturna

Strength

Dosage Instructions

Quantity

Days Supply

Diagnosis:

Preferred ACE Inhibitor Trial: Drug Name Strength

Dosage Instructions Trial date from: Trial date to:

Failure reason with ACE Inhibitor:

Medical or contraindication reason to override ACE Inhibitor trial requirements:

Reason for use of Non-Preferred drug requiring prior approval:

Other relevant information:

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.) Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only.