

Entresto (sacubitril/valsartan) Prior Authorization Request Form



Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME:		MEMBER'S FIRST NAME:	
	l applicable sections completel ., chart notes or lab data, to su Information under HIPAA.		
			URGENT
MEMBER INFORMATION			
LAST NAME:		FIRST NAME:	
PHONE NUMBER:		DATE OF BIRTH:	
STREET ADDRESS:			
CITY:		STATE: ZIP CODE:	
PATIENT INSURANCE ID NU	MBER:	1	
IF YOU ARE NOT THE PATIENT OR THE PRESCI FOLLOWING LINK: <u>HTTPS://MAGELLANRX.CC</u>	GHT (IN/CM): WEIGH RIBER, YOU WILL NEED TO SUBMIT A PHI DISCLE DM/MEMBER/EXTERNAL/COMMERCIAL/COMM RESENTATIVE (IF APPLICABLE):	OSURE AUTHORIZATION FORM WITH THIS REQUINED TO SERVICE AUTHORIZATION FOR AUTHORIZATI	UEST WHICH CAN BE FOUND AT THE ATION.PDF
	VE'S PHONE NUMBER:		
PRESCRIBER INFORMATION			
LAST NAME:		FIRST NAME:	
PRESCRIBER SPECIALTY:		EMAIL ADDRESS:	
NPI NUMBER:		DEA NUMBER:	
PHONE NUMBER:		FAX NUMBER:	
STREET ADDRESS:			
CITY:		STATE: ZIP CODE:	
REQUESTOR (if different than prescriber):		OFFICE CONTACT PERSON:	
MEDICATION OR MEDICAL	DISPENSING INFORMATION		
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
■ NEW THERAPY	RENEWAL	IF RENEWAL: DATE THERAPY	INITIATED:
DURATION OF THERAPY (SP	ECIFIC DATES):		

Continued on next page.



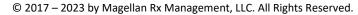


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MEMBER'S LAST NAME: MEMBER'S FIRST NAME:		NAME:
1. HAS THE PATIENT TRIED ANY OTHE	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES:		ICD-10:
□ Systolic left ventricular dysfunction□ Diastolic dysfunction (HFpEF)	•	
3. REQUIRED CLINICAL INFORMATION PRIOR AUTHORIZATION.	I: PLEASE PROVIDE ALL RELEVANT CLINIC	CAL INFORMATION TO SUPPORT A
For all diagnoses, please answer the find its patient NYHA Class II, III, or IV? Y		
For Systolic left ventricular dysfunction Does the patient have an ejection fra	on(HFrEF): ction of 40% or less? \square Yes \square No <i>Please</i>	submit chart documentation.
	ystolic left ventricular dysfunction(HFrE (s) for chronic heart failure? ☐ Yes ☐ No	
Does patient has evidence of structur	n(HFpEF), please answer the following: al heart damage, including either left ver left atrial(LA) enlargement (i.e. width > pentation.	
Does patient have a BMI >40kgm2?	Yes □ No Please submit chart documen	ntation.
	disease including severe COPD, requirin nronic oral steroid therapy for treatmen	
Does patient have severe <u>pulmonary</u> submit chart documentation.	disease including primary pulmonary hy	pertension? □ Yes □ No <i>Please</i>
significant mitral valve regurgitation	n or diagnosis causing patient's heart fa causing the heart failure, any dilated car myopathy, or viral myocarditis? Yes	diomyopathy, infiltrative
Has patient been using a diuretic for a	at least 30 days? □ Yes □ No <i>Please sub</i>	mit chart documentation.
□No Please submit chart documenta	past 9 months of starting Entresto, is pation. by heart failure, is patient's NT-proBNP >	
chart documentation	• •	- - -



Revision Date: 9/15/2022

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If patient has atrial fibrillation, is patient's NT-prol documentation.	BNP > 900pg/ml? Yes No Please submit chart
IF NT-proBNP not available, does patient have a B submit chart documentation.	BNP >100pg/ml without kidney failure? Yes No Please
If NT-proBNP not available and patient has kidney submit chart documentation.	failure, does patient have a BNP>200pg/ml? Yes No Please
If NT-proBNP not available and patient has Atrial f Please submit chart documentation.	fibrillation(AF), does patient have a BNP >150pg/ml? ☐ Yes ☐ No
Are there any other comments, diagnoses, sympto physician feels is important to this review?	oms, medications tried or failed, and/or any other information the
Please note: Not all drugs/diagnosis are covered or information is received.	n all plans. This request may be denied unless all required
•	true and accurate to the best of my knowledge. I understand that mees may perform a routine audit and request the medical information reported on this form.
Prescriber Signature or Electronic I.D. Verification:	: Date:
	transmission contain confidential health information that is legally privileged. If at any disclosure, copying, distribution, or action taken in reliance on the contents

of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640

FAX 1013 FURIVI 10: 800-424-7040

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program

Attn: CP - 4201 P.O. Box 64811 St. Paul, MN 55164-0811

