



This form is based on Express Scripts standard criteria and may not be applicable to all patients; certain plans and situations may require additional information beyond what is specifically requested.

Additional forms available: www.express-scripts.com/pa

Fax completed form to **1-800-357-9577**
If this an **URGENT** request, please call 1-800-417-8164

Patient Information

Patient First Name: _____
Patient Last Name: _____
Patient ID#: _____
Patient DOB: _____
Patient Phone #: _____

Prescriber Information

Prescriber Name: _____
Prescriber DEA/NPI (required): _____
Prescriber Phone #: _____
Prescriber Fax #: _____
Prescriber Address: _____
State: _____ Zip Code: _____

Primary Diagnosis: _____ ICD Code: _____

Please indicate which drug and strength is being requested:

- | | | |
|--|--|---|
| <input type="checkbox"/> Atacand 4mg | <input type="checkbox"/> Cozaar 50mg | <input type="checkbox"/> Hyzaar 50mg-12.5mg |
| <input type="checkbox"/> Atacand 8mg | <input type="checkbox"/> Cozaar 100mg | <input type="checkbox"/> Hyzaar 100mg-12.5mg |
| <input type="checkbox"/> Atacand 16mg | <input type="checkbox"/> Diovan 40mg | <input type="checkbox"/> Hyzaar 100mg-25mg |
| <input type="checkbox"/> Atacand 32mg | <input type="checkbox"/> Diovan 80mg | <input type="checkbox"/> Micardis HCT 40mg-12.5mg |
| <input type="checkbox"/> Atacand HCT 16mg-12.5mg | <input type="checkbox"/> Diovan 160mg | <input type="checkbox"/> Micardis HCT 80mg-12.5mg |
| <input type="checkbox"/> Atacand HCT 32mg-12.5mg | <input type="checkbox"/> Diovan 320mg | <input type="checkbox"/> Micardis HCT 80mg-25mg |
| <input type="checkbox"/> Atacand HCT 32mg-25mg | <input type="checkbox"/> Diovan HCT 80mg-12.5mg | <input type="checkbox"/> Micardis 20mg |
| <input type="checkbox"/> Avalide 150mg-12.5mg | <input type="checkbox"/> Diovan HCT 160mg-12.5mg | <input type="checkbox"/> Micardis 40mg |
| <input type="checkbox"/> Avalide 300mg-12.5mg | <input type="checkbox"/> Diovan HCT 160mg-25mg | <input type="checkbox"/> Micardis 80mg |
| <input type="checkbox"/> Avalide 300mg-25mg | <input type="checkbox"/> Diovan HCT 320mg-12.5mg | <input type="checkbox"/> Teveten 400mg |
| <input type="checkbox"/> Avapro 75mg | <input type="checkbox"/> Diovan HCT 320mg-25mg | <input type="checkbox"/> Teveten 600mg |
| <input type="checkbox"/> Avapro 150mg | <input type="checkbox"/> Edarbi 40mg | <input type="checkbox"/> Teveten HCT 600mg-12.5mg |
| <input type="checkbox"/> Avapro 300mg | <input type="checkbox"/> Edarbi 80mg | <input type="checkbox"/> Teveten HCT 600mg-25mg |
| <input type="checkbox"/> Azor 5mg-20mg | <input type="checkbox"/> Exforge 5mg-160mg | <input type="checkbox"/> Tribenzor 20mg-5mg-12.5mg |
| <input type="checkbox"/> Azor 5mg-40mg | <input type="checkbox"/> Exforge 5mg-320mg | <input type="checkbox"/> Tribenzor 40mg-5mg-12.5mg |
| <input type="checkbox"/> Azor 10mg-20mg | <input type="checkbox"/> Exforge 10mg-160mg | <input type="checkbox"/> Tribenzor 40mg-5mg-25mg |
| <input type="checkbox"/> Azor 10mg-40mg | <input type="checkbox"/> Exforge 10mg-320mg | <input type="checkbox"/> Tribenzor 40mg-10mg-12.5mg |
| <input type="checkbox"/> Benicar 5mg | <input type="checkbox"/> Exforge HCT 5mg-160mg-12.5mg | <input type="checkbox"/> Tribenzor 40mg-10mg-25mg |
| <input type="checkbox"/> Benicar 20mg | <input type="checkbox"/> Exforge HCT 5mg-160mg-25mg | <input type="checkbox"/> Twynsta 40mg-5mg |
| <input type="checkbox"/> Benicar 40mg | <input type="checkbox"/> Exforge HCT 10mg-160mg-12.5mg | <input type="checkbox"/> Twynsta 40mg-10mg |
| <input type="checkbox"/> Benicar HCT 20mg-12.5mg | <input type="checkbox"/> Exforge HCT 10mg-160mg-25mg | <input type="checkbox"/> Twynsta 80mg-5mg |
| <input type="checkbox"/> Benicar HCT 40mg-12.5mg | <input type="checkbox"/> Exforge HCT 10mg-320mg-25mg | <input type="checkbox"/> Twynsta 80mg-10mg |
| <input type="checkbox"/> Benicar HCT 40mg-25mg | | |

Directions for use (i.e. QD, BID, PRN & Qty): _____

Please complete the clinical assessment:

1. Is the patient currently taking the A-II antagonist (ARB) or A-II antagonist (ARB) combination product being requested? If yes, how long has the patient been taking the medication? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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2. Is the patient taking samples or paying 100% out of pocket for the medication being requested?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Has the patient tried one ACE inhibitor or ACE inhibitor combination product OR generic losartan or generic losartan combination product? If yes, please list: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Has the patient tried Diovan or Diovan HCT, Azor, Tribenzor, Exforge or Exforge HCT? If yes, please list: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Was the patient recently hospitalized and discharged within the previous 30 days for a cardiovascular (CV) event (e.g. myocardial infarction (MI), hypertensive emergency, decompensated heart failure) AND has been started and stabilized on the requested medication? If yes, please document specific CV event and hospitalization date: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Does the patient have heart failure AND has tried one ACE inhibitor or ACE inhibitor combination product OR generic losartan or generic losartan combination product? If yes, please list: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Are there any other comments, diagnoses, symptoms, and/or any other information the physician feels is important to this review?

Prescriber Signature: _____	Date: _____
Office Contact Name: _____ Phone Number: _____	

Based upon each patient’s prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact our prior authorization team at the number listed on the top of this form.

Prior Authorization of Benefits is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for the patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

The document(s) accompanying this transmission may contain confidential health information. This information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you received this information in error, please notify the sender immediately and arrange for the return or destruction of the documents.