aetna™

Aetna Better Health®

Fax completed prior authorization request form to 844-802-1412 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at https://www.aetnabetterhealth.com/Illinois-medicaid

Entresto

Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information					
Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): ☐Yes ☐No	Diagnosis:	ICD-10 Code:			
Are there any contraindications to formulary medications? If yes, please specify:		☐ Yes	☐ No	☐ New request	
☐ Continuation of therapy ONLY:	Was there response to treatment?	☐ Yes	☐ No		
	Was Entresto used with other HF therapies (BB, aldosterone antagonist OR combination therapy with hydralazine AND isosorbide dinitrate)?	☐ Yes	☐ No		
	Is member a female AND of childbearing age?	☐ Yes	☐ No		
	Is member pregnant?	☐ Yes	☐ No	☐ N/A	
	Was combination therapy with hydralazine AND isosorbide dinitrate used?	☐ Yes	☐ No		
Directions for Use:	Strength:	Dosage Form:			
	Quantity:	Day Supply:	Duration of Therapy/Use:		
What medication(s) has member tried and failed for this diagnosis? Please specify below.					

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information					
Will medication be used concomitantly OR within 36 hours of last dose of ACEI OR medication containing aliskiren (Tekturna OR Tekturna-HCTZ)?	☐ Yes	☐ No	Does member have severe hepatic impairment (Child Pugh Class C) AND history of angioedema?	☐ Yes	☐ No
Is member a female AND of childbearing age?	☐ Yes	☐ No	Is member pregnant?	☐ Yes	☐ No
☐ **Members Ages 18 Years OR Older**					
Does member have NYHA Class II-IV chronic HF with reduced ejection fraction ≤40%?				☐ Yes	☐ No
Is member tolerating an ARB OR an ACEI?	☐ Yes	☐ No	Will Entresto replace the ARB and/or ACEI?	☐ Yes	☐ No

Proprietary

Will Entresto be used in conjunction with other HF therapies (beta blockers, aldosterone antagonist OR combination therapy with hydralazine AND isosorbide dinitrate)?				☐ Yes	☐ No
☐ **Members Ages 1 Year OR Older**					
Does member have symptomatic HF and systemic left ventricular systolic dysfunction?	☐ Yes	☐ No	Has member tried AND failed enalapril?	☐ Yes	☐ No
Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.					

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 866-329-4701 to check the status of a request.

Proprietary