UnitedHealthcare Community Plan

Entresto
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
NPI #:	Phone:	Fax:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS:

- **Is this request for a continuation of prior Entresto therapy initiated during an inpatient stay? □ Yes □ No**
  If yes, list start date: _____

- **Does the patient have a diagnosis of heart failure (with or without hypertension)? □ Yes □ No**
  If no, list diagnosis: _____

- **Patient's ejection fraction: _____ %**

- **Is the patient's heart failure classified as one of the following New York American Heart Association classes?**
  □ Yes □ No (If yes, check which applies) □ Class II □ Class III □ Class IV

- **Is the patient on a stabilized dose and receiving concomitant therapy with one of the following beta-blockers:**
  □ Yes □ No (If yes, check which applies) □ Bisoprolol □ Carvedilol □ Metoprolol succinate

- **Does the patient have a contraindication or intolerance to beta-blocker therapy? □ Yes □ No**
  If yes, list contraindication: _____

- **Does the patient have a history of angioedema? □ Yes □ No**

- **Will the patient discontinue any use of concomitant ACE Inhibitor or ARB before initiating treatment with Entresto?**
  □ Yes □ No

- **Is the patient concomitantly on aliskiren therapy? □ Yes □ No**

- **Is Entresto prescribed by, or in consultation with, a cardiologist? □ Yes □ No**

Requests for CONTINUATION OF THERAPY:

- **Has the Entresto dose been titrated to a dose of 97mg/103mg twice daily, or to a maximum dose as tolerated by the patient? □ Yes □ No**

- **Does the patient have a documented positive clinical response to Entresto therapy? □ Yes □ No**
  If yes, list response: _____
  _____

Provider Signature: _____ Date: _____