## Prior Authorization Form

# Oral antihypertensive agents

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

**Drug requested:** ☐ Diovan® ☐ Diovan HCT®, ☐ Benicar® ☐ Benicar HCT®, ☐ Cozaar® ☐ Hyzaar®, ☐ Azor ☐ Exforge ☐Tekturna HCT ☐ Avapro® ☐Avalide®, ☐ Teveten® ☐ Teveten ☐ Micardis® ☐ Micardis HCT®, ☐ Atacand® ☐ Atacand HCT® ☐ Tekturna

Date: ____________________ Patient ID#: ______________ DOB:__________

Patient Name: ________________________ Provider NPI: ________________________

Prescribing Physician: ____________________ Office Contact: ______________________

Office Fax #: ________________________ Office Phone: ________________________

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

### 1. DIAGNOSIS FOR DRUG REQUESTED:

☐ Hypertension ☐ Type II Diabetes with renal insufficiency ☐ Other (specify)____________________

### 2. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

☐ **N/A** If none or not applicable to diagnosis, indicate "N/A."

| Drug Name | Date | Duration |
|---|---|---|
| ______________ | ______________ | ______________ |
| ______________ | ______________ | ______________ |
| ______________ | ______________ | ______________ |

### 3. PATIENT HISTORY:

**a.** Has the patient tried and failed an ACE containing product for a minimum of 30 days? ☐ Yes ☐ No
**b.** Has the patient tried and failed an ACE containing product in the past 6 months? ☐ Yes ☐ No
**c.** Does the patient have an intolerance or contraindication to an ACE containing product? ☐ Yes ☐ No
**Please specify** ____________________________________________

____________________________________________

**FOR THE FOLLOWING QUESTIONS (D, E, F, G) DOCUMENT THE DATES IN THE MEDICATION HISTORY SECTION**

**d.** Has the patient tried and failed a Diovan containing product for a minimum of 30 days? ☐ Yes ☐ No ☐ N/A
**e.** Has the patient tried and failed a Benicar containing product for a minimum of 30 days? ☐ Yes ☐ No ☐ N/A
**f.** Has the patient tried an amlodipine containing product for a minimum of 30 days? ☐ Yes ☐ No ☐ N/A
**g.** Is the patient non-compliant? ☐ Yes ☐ No ☐ N/A

**Tekturna Only**

**h.** Has the patient tried and failed or has a contraindication/intolerance/allergy to an ACE containing product? ☐ Yes ☐ No
**i.** Has the patient tried and failed or has a contraindication to a Diovan containing product? ☐ Yes ☐ No
**j.** Has the patient tried and failed or has a contraindication to a Benicar containing product? ☐ Yes ☐ No
**k.** Has the patient tried and failed or has a contraindication to an amlodipine containing product? ☐ Yes ☐ No

Please add any other supporting medical information that may be useful in the decision-making process:

____________________________________________
____________________________________________
____________________________________________

**FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.**

| **Internal use only** | | | **Coverage effective date** / / | | |
|---|---|---|---|---|---|
| Document #______________ | | | Processor Initials________ | Date______________ | |
| M F Rx coverage | Y | N | STANDARD - SELECT | LOB______________ | |
| Previous Auth | Y | N | **Approved** | **Reviewer Initials**________ | Date________ |



Independence Blue Cross offers products directly, through its subsidiaries Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield. Independent licensees of the Blue Cross and Blue Shield Association.