EXPRESS SCRIPTS®

Prior Authorization Form
ARB Step Therapy

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 **1-877-329-3760**
If this an **URGENT** request, please call 1-800-753-2851

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:

- ☐ Atacand 4mg
- ☐ Atacand 8mg
- ☐ Atacand 16mg
- ☐ Atacand 32mg
- ☐ Atacand HCT 16mg-12.5mg
- ☐ Atacand HCT 32mg-12.5mg
- ☐ Atacand HCT 32mg-25mg
- ☐ Avalide 150mg-12.5mg
- ☐ Avalide 300mg-12.5mg
- ☐ Avalide 300mg-25mg
- ☐ Avapro 75mg
- ☐ Avapro 150mg
- ☐ Avapro 300mg
- ☐ Azor 5mg-20mg
- ☐ Azor 5mg-40mg
- ☐ Azor 10mg-20mg
- ☐ Azor 10mg-40mg
- ☐ Benicar 5mg
- ☐ Benicar 20mg
- ☐ Benicar 40mg
- ☐ Benicar HCT 20mg-12.5mg
- ☐ Benicar HCT 40mg-12.5mg
- ☐ Benicar HCT 40mg-25mg
- ☐ Cozaar 50mg
- ☐ Cozaar 100mg
- ☐ Diovan 40mg
- ☐ Diovan 80mg
- ☐ Diovan 160mg
- ☐ Diovan 320mg
- ☐ Diovan HCT 80mg-12.5mg
- ☐ Diovan HCT 160mg-12.5mg
- ☐ Diovan HCT 160mg-25mg
- ☐ Diovan HCT 320mg-12.5mg
- ☐ Diovan HCT 320mg-25mg
- ☐ Edarbi 40mg
- ☐ Edarbi 80mg
- ☐ Edarbyclor 40mg-12.5mg
- ☐ Edarbyclor 40mg-25mg
- ☐ Exforge 5mg-160mg
- ☐ Exforge 5mg-320mg
- ☐ Exforge 10mg-160mg
- ☐ Exforge 10mg-320mg
- ☐ Exforge HCT 5mg-160mg-12.5mg
- ☐ Exforge HCT 5mg-160mg-25mg
- ☐ Exforge HCT 10mg-160mg-12.5mg
- ☐ Hyzaar 50mg-12.5mg
- ☐ Hyzaar 100mg-12.5mg
- ☐ Hyzaar 100mg-25mg
- ☐ Micardis HCT 40mg-12.5mg
- ☐ Micardis HCT 80mg-12.5mg
- ☐ Micardis HCT 80mg-25mg
- ☐ Micardis 20mg
- ☐ Micardis 40mg
- ☐ Micardis 80mg
- ☐ Teveten 400mg
- ☐ Teveten 600mg
- ☐ Teveten HCT 600mg-12.5mg
- ☐ Teveten HCT 600mg-25mg
- ☐ Tribenzor 20mg-5mg-12.5mg
- ☐ Tribenzor 40mg-5mg-12.5mg
- ☐ Tribenzor 40mg-5mg-25mg
- ☐ Tribenzor 40mg-10mg-12.5mg
- ☐ Tribenzor 40mg-10mg-25mg
- ☐ Twynsta 40mg-5mg
- ☐ Twynsta 40mg-10mg
- ☐ Twynsta 80mg-5mg
- ☐ Twynsta 80mg-10mg

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? _____	☐ Yes	☐ No

2. Is the patient taking samples or paying 100% out of pocket for the medication being requested?	☐ Yes	☐ No
3. Has the patient tried one ACE inhibitor or ACE inhibitor combination product OR generic ARB or generic ARB combination product? If yes, please list: _____	☐ Yes	☐ No
4. Has the patient tried Azor, Tribenzor, Benicar, Benicar HCT, Exforge or Exforge HCT? If yes, please list: _____	☐ Yes	☐ 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: _____	☐ Yes	☐ No
6. Does the patient have heart failure AND has tried one ACE inhibitor or ACE inhibitor combination product OR generic ARB or generic ARB combination product? If yes, please list: _____	☐ Yes	☐ No
7. Does the patient have heart failure AND the generic equivalents of Atacand (candesartan) and Diovan (valsartan) not available?	☐ Yes	☐ No

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

_____

_____

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_____

_____

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.