AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization

Angiotensin Receptor Blocker Before ACE Inhibitor

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:	Patient name:	
Patient address:		DOB:
Provider NPI:	Prescriber name:	Phone:
Prescriber address:		Fax:
Pharmacy name:		
Address:		Phone:
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI:	Pharmacy fax:	NDC:

Payment for angiotensin receptor blockers (ARB) and angiotensin receptor blocker combinations will only be considered for cases in which there is a contraindication or therapy failure with at least one ACE-I or ACE-I combination. A completed prior authorization form will need to be submitted if a trial with an ACE-I or ACE-I combination of at least 30 days in length is not found in the point-of-sale system and/or unless evidence is provided that use of an ACE-I or ACE-I combination would be medically contraindicated. Prior authorization is required for all non-preferred ARBs and ARB combinations the first day of therapy. Payment for a non-preferred ARB or ARB combination will be considered following documentation of recent trials and therapy failures with a preferred ACE-I or ACE-I combination AND a preferred ARB or ARB combination.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

Preferred:	**Non-Preferred:**			
☐ Amlodipine-Olmesartan	☐ Amlodipine/Valsartan	☐ Cozaar	☐ Micardis	☐ Teveten HCT
☐ Irbesartan	☐ Amlodipine/Valsartan/HCTZ	☐ Diovan	☐ Micardis HCT	☐ Tribenzor
☐ Irbesartan HCT	☐ Atacand	☐ Diovan HCT	☐ Olmesartan	☐ Twynsta
☐ Losartan	☐ Atacand HCT	☐ Edarbi	☐ Olmesartan-Amlodipine-HCTZ	☐ Valturna
☐ Losartan HCT	☐ Avalide	☐ Edarbyclor	☐ Olmesartan-HCTZ	
☐ Valsartan	☐ Avapro	☐ Eprosartan	☐ Telmisartan	
☐ Valsartan HCT	☐ Azor	☐ Exforge	☐ Telmisartan/Amlodipine	
	☐ Benicar	☐ Exforge HCT	☐ Telmisartan HCT	
	☐ Benicar HCT	☐ Hyzaar	☐ Teveten	

Strength: Dosage instructions: Quantity: Days supply:

Diagnosis:

Preferred ACE Inhibitor Trial:

Drug name: Strength:

Dosage instructions: Trial date from: Trial date to:

Failure reason with ACE inhibitor:

Medical or contraindication reason to override ACE inhibitor trial requirements:

Reason for use of non-preferred drug requiring prior approval:

Other relevant information:

AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Angiotensin Receptor Blocker Before ACE Inhibitor

Please print – accuracy is important.

Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste, and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.

Prescriber signature: (Must match prescriber listed above.)	Date of submission:

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.