AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization

Valsartan/Sacubitril (Entresto™)

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:

Prior authorization is required for valsartan/sacubitril (Entresto). Requests above the manufacturer recommended dosing will not be considered. Payment will be considered for patients when the following criteria are met:

1. Patient is 18 years of age or older; and
2. Patient has a diagnosis of NYHA Functional Class II, III, or IV heart failure; and
3. Patient has a left ventricular ejection fraction (LVEF) ≤40%; and
4. Patient has documentation of a previous trial and therapy failure or intolerance to an ACE inhibitor at maximally tolerated dose; and
5. Patient has documentation of a previous trial and therapy failure or intolerance to an angiotensin II receptor blocker (ARB); and
6. Is to be administered in conjunction with other heart failure therapies, in place of an ACE inhibitor or other ARB (list medications patient is currently taking for the treatment of heart failure); and
7. Will not be used in combination with an ACE inhibitor or ARB; and
8. Will not be used in combination with aliskiren (Tekturna®) in diabetic patients; and
9. Patient does not have a history of angioedema associated with the use of ACE inhibitor or ARB therapy; and
10. Patient is not pregnant; and
11. Patient does not have severe hepatic impairment (Child Pugh Class C); and
12. Prescriber is a cardiologist or has consulted with a cardiologist (telephone consultation is acceptable).

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

If the criteria for coverage are met, initial authorization will be given for 3 months. Requests for continuation of therapy may be provided if prescriber documents adequate response to therapy.

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

Non-Preferred:

☐ **Entresto**

Strength: Quantity: Days Supply:

Dosage Instructions:

Diagnosis:

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Trial information:

ACE inhibitor trial: Dose: Trial dates:

Reason for failure:

ARB trial: Drug name and dose: Trial dates:

Reason for failure:

Medical or contraindication reason to override ACE Inhibitor/ARB trial requirements:

Will Entresto be used in combination with ACE inhibitor or ARB? ☐ Yes ☐ No

Does patient have a history of angioedema associated with ACE inhibitor or ARB therapy? ☐ Yes ☐ No

Provide heart failure therapies to be used in conjunction with Entresto:

If patient is diabetic, will Entresto be used in combination with aliskiren (Tekturna)? ☐ Yes ☐ No

Provide patient's left ventricular ejection fraction:

Date obtained:

Results:

If female of child-bearing years, confirmed negative serum pregnancy test? ☐ Yes ☐ No

If yes, please list Prescriber:

Date of pregnancy test:

Does patient have severe hepatic impairment (Child Pugh Class C)? ☐ Yes ☐ No

Is Prescriber a cardiologist? ☐ Yes ☐ No

If no, note consultation with cardiologist:

Consultation date: Physician name & phone:

Renewal Requests: Provide documentation of adequate response to treatment:

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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.