

NC Pharmacy Prior Approval Request for Entresto

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): up to 30 Days 60 Days 90 Days 120 Days 180 Days 365 Days

Clinical Information

1. Does the beneficiary have a diagnosis of chronic heart failure (NYHA class II-IV) with a left ventricular ejection fraction (EF) less than or equal to 40%? Yes No List ejection fraction: _____
2. Does the beneficiary have a history of angioedema related to therapy with an ACE inhibitor or ARB? Yes No
- 3a. Is the beneficiary currently taking an ACE inhibitor or ARB? Yes No
- 3b. If the beneficiary is currently taking an ACE inhibitor or ARB, will Entresto replace that current therapy?
 Yes No
- 4a. Does the beneficiary have diabetes? Yes No
- 4b. If the beneficiary has diabetes, is the beneficiary taking a medication containing aliskiren (e.g. Tekturna or Tekturna HCT)? Yes No

For reauthorization, please answer questions 1-5

5. Is documentation attached to this request that indicates the beneficiary is receiving clinical benefit from Entresto such as stabilization of symptoms, improvement? Yes No

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.