

Prior Authorization Form

Entresto

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Entresto.

Drug Name (select from list of drugs shown)
Entresto (sacubitril-valsartan)

Quantity	Frequency	Strength	
Route of Administration	Expected Length of Therapy		

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Does the patient have any of the following: A) a history of angioedema related to previous ACE inhibitor or ARB therapy, B) concomitant use of ACE inhibitors or ARBs, C) concomitant use of aliskiren in a patient with diabetes, or D) pregnancy? Y N

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2. Does the patient have the diagnosis of chronic heart failure (NYHA Class II-IV) and reduced ejection fraction less than or equal to 40 percent?

Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date