CareFirst Family of health care plans

CVS caremark™

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

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