PA Request Criteria

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CAREFIRST VA EXCHANGE
Entresto

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 855-582-2022 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Entresto.

Patient Name: _____ **Date:** 5/20/2022
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: **Patient Phone:** **Physician Name:**
_____ **NPI#:** _____ **Specialty:**
_____ **Physician Office Telephone:**
Physician Office Address: _____
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Drug Name (select from list of drugs shown)
Entresto (sacubitril-valsartan)

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

1.	Is the patient 18 years of age or older?	**Y** ☐	**N** ☐
2.	Is the requested drug being prescribed to reduce the risk of cardiovascular death and hospitalization for heart failure?	**Y** ☐	**N** ☐
3.	Does the patient have a diagnosis of symptomatic chronic heart failure?	**Y** ☐	**N** ☐
4.	Does the patient have a left ventricular ejection fraction (LVEF) less than or equal to 40 percent? Left ventricular ejection fraction percentage. _____	**Y** ☐	**N** ☐
5.	Will the patient receive concomitant treatment with a maximally tolerated dose of a betablocker (e.g., carvedilol, metoprolol succinate, bisoprolol)?	**Y** ☐	**N** ☐
6.	Has the patient experienced an intolerance to a beta-blocker (e.g., carvedilol, metoprolol succinate, bisoprolol)?	**Y** ☐	**N** ☐
7.	Does the patient have a contraindication that would prohibit a trial of a beta-blocker (e.g., carvedilol, metoprolol succinate, bisoprolol)?	**Y** ☐	**N** ☐
8.	Does the patient have structural heart disease (i.e., left atrial enlargement [LAE], left ventricular hypertrophy [LVH])? [Note: If yes, then prescriber MUST submit chart notes or other documentation supporting a diagnosis of structural heart disease.]	**Y** ☐	**N** ☐
9.	Is this request for a pediatric patient one year of age or older?	**Y** ☐	**N** ☐
10.	Is the requested drug being prescribed for the treatment of symptomatic heart failure with systemic left ventricular systolic dysfunction?	**Y** ☐	**N** ☐
11.	Does the patient have a diagnosis of diabetes?	**Y** ☐	**N** ☐
12.	Does the patient have renal impairment (estimated Glomerular Filtration Rate [eGFR] less than 60 milliliters per minute per 1.73 meters squared [mL/min/1.73m2])?	**Y** ☐	**N** ☐
13.	Will the requested drug be used in combination with Tekturna (aliskiren)?	**Y** ☐	**N** ☐

Comments: _____

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Please check the appropriate answer for each applicable question.

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date