



Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/completecure-forproviders/pharmacy

Entresto Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification to support diagnosis

Member Information							
Member Name (first & last):		Date of Birth:		Gender:		Height:	
				<input type="checkbox"/> Male <input type="checkbox"/> Female			
Member ID:		City:		State:		Weight:	
Prescribing Provider Information							
Provider Name (first & last):		Specialty:		NPI#		DEA#	
Office Address:		City:		State:		Zip Code:	
Office Contact:			Office Phone		Office Fax:		
Dispensing Pharmacy Information							
Pharmacy Name:			Pharmacy Phone:		Pharmacy Fax:		
Requested Medication Information							
Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): Yes No			Diagnosis:		ICD-10 Code:		
Are there any contraindications to formulary medications? If yes, please specify:					<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> New request
<input type="checkbox"/> Continuation of therapy ONLY:	Was there response to treatment?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Was Entresto used with other HF therapies (BB, aldosterone antagonist OR combination therapy with hydralazine AND isosorbide dinitrate)?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Is member a female AND of childbearing age?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Is member pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A			
	Was combination therapy with hydralazine AND isosorbide dinitrate used?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
Directions for Use:			Strength:		Dosage Form:		
			Quantity:	Day Supply:	Duration of Therapy/Use:		
What medication(s) has member tried and failed for this diagnosis? Please specify below.							
Turn-Around Time for Review							
<input type="checkbox"/> Standard – (24 hours)			<input type="checkbox"/> Urgent – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision.				
						Signature: _____	
Clinical Information							
Will medication be used concomitantly OR within 36 hours of last dose of ACEI OR medication containing aliskiren (Tekturna OR Tekturna-HCTZ)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does member have severe hepatic impairment (Child Pugh Class C) AND history of angioedema?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is member a female AND of childbearing age?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is member pregnant?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Members Ages 18 Years OR Older							
Does member have NYHA Class II-IV chronic HF with reduced ejection fraction ≤40%?					<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is member tolerating an ARB OR an ACEI?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Will Entresto replace the ARB and/or ACEI?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Will Entresto be used in conjunction with other HF therapies (beta blockers, aldosterone antagonist OR combination therapy with hydralazine AND isosorbide dinitrate)?					<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Members Ages 1 Year OR Older							
Does member have symptomatic HF and systemic left ventricular systolic dysfunction?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has member tried AND failed enalapril?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.							

[Empty box for notes or signature]

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ Date: _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.
Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request.