Entresto (sacubitril/valsartan)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Systolic left ventricular dysfunction(HFrEF) ☐ Diastolic dysfunction (HFpEF)	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

For all diagnoses, please answer the following:
Is patient NYHA Class II, III, or IV? □ Yes □ No

For Systolic left ventricular dysfunction(HFrEF):
Does the patient have an ejection fraction of 40% or less? □ Yes □ No *Please submit chart documentation.*

For patient 1 to 17years of age with Systolic left ventricular dysfunction(HFrEF:
Is patient receiving other medication(s) for chronic heart failure? □ Yes □ No *Please submit chart documentation.*

For patients with Diastolic dysfunction(HFpEF), please answer the following:
Does patient has evidence of structural heart damage, including either left ventricular hypertrophy(LVH) (i.e. septal or posterior wall thickness >1.1cm, or left atrial(LA) enlargement (i.e. width >55ml, or volume index > 29ml/m2)? □ Yes □ No *Please submit chart documentation.*

Does patient have a BMI >40kgm2? □ Yes □ No *Please submit chart documentation.*

Does patient have severe pulmonary disease including severe COPD, requiring home oxygen therapy for their COPD, chronic nebulizer therapy or chronic oral steroid therapy for treatment of their severe COPD? □ Yes □ No *Please submit chart documentation.*

Does patient have severe pulmonary disease including primary pulmonary hypertension? □ Yes □ No *Please submit chart documentation.*

Does patient have any other condition or diagnosis causing patient's heart failure symptoms such as patient has significant mitral valve regurgitation causing the heart failure, any dilated cardiomyopathy, infiltrative cardiomyopathy, drug induced cardiomyopathy, or viral myocarditis? □ Yes □ No *Please submit chart documentation.*

Has patient been using a diuretic for at least 30 days? □ Yes □ No *Please submit chart documentation.*

If hospitalized for heart failure within past 9 months of starting Entresto, is patient's NT-proBNP >200pg/ml? □ Yes □No *Please submit chart documentation.*
If not hospitalized in past 9 months for heart failure, is patient's NT-proBNP >300pg/ml? □ Yes □ No *Please submit chart documentation.*

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If patient has atrial fibrillation, is patient's NT-proBNP > 900pg/ml? □ **Yes** □ **No** ***Please submit chart documentation.***

IF NT-proBNP not available, does patient have a BNP >100pg/ml without kidney failure? □ **Yes** □ **No** ***Please submit chart documentation.***

If NT-proBNP not available and patient has kidney failure, does patient have a BNP>200pg/ml? □ **Yes** □ **No** ***Please submit chart documentation.***

If NT-proBNP not available and patient has Atrial fibrillation(AF), does patient have a BNP >150pg/ml? □ **Yes** □ **No** ***Please submit chart documentation.***

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811
St. Paul, MN 55164-0811