



Date _____

PRIOR AUTHORIZATION CRITERIA – Edarbi™

Prescriber Last Name: _____	Prescriber First Name: _____
Prescriber Phone: _____	Prescriber Fax: _____
Patient _____	ID# _____ DOB _____

****FAILURE TO COMPLETE THE FORM MAY RESULT IN A DELAY OR AN AUTOMATIC DENIAL****

1. Is the patient in the 2nd or 3rd trimester of pregnancy? Yes No
2. Is the patient currently stable on the medication? Yes No
 - a. If Yes, provide the date therapy was initiated _____
3. Has the patient tried/failed a generic ACE Inhibitor (ACE-I) / ACE-I combo or generic losartan / losartan HCTZ? Yes No
 - a. If Yes, specify drug and dates of trial _____
 - b. If No, provide the rationale for non-trial _____
4. Provide dates of trial/failure of candesartan/HCTZ: _____
5. Provide dates of trial/failure of irbesartan / irbesartan/HCTZ: _____
6. Provide dates of trial/failure of valsartan/HCTZ: _____
7. Provide dates of trial/failure of Azor®: _____
8. Provide dates of trial/failure of Benicar® / Benicar HCT®: _____
9. Provide dates of trial/failure of Micardis® / Micardis HCT®: _____
10. Prescriber Signature or name and title of staff person providing answers _____

Prescriber Comments _____

Send or Fax completed form to:

877-329-7279

Restat
11900 W. Lake Park Dr.
Milwaukee, WI 53224

QUESTIONS PLEASE CALL:

877-526-9906

*****DISCLOSURE STATEMENT*****

www.restat.com

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