restat
a Catamaran company

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

www.restat.com

QUESTIONS PLEASE CALL:
877-526-9906

 Date 4/1/2013